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Sheri Bortner

PROGRAM PLANNING IMPLEMENTATION AND EVALUATION FOR DEAF-BLIND CHILDREN

Kentucky State Deaf-Blind Workshop
Louisville, Kentucky
April 27-29, 1977

RESOURCE BOOK

[illegible]
Scales and
munication
Behaviors
Auditory
Motor
Visual
elf-Help

PROGRAM PLANNING, IMPLEMENTATION, AND EVALUATION FOR DEAF-BLIND CHILDREN

CO-SPONSORED BY
KENTUCKY SCHOOL FOR THE BLIND
AND
CHILD EVALUATION CENTER
UNIVERSITY OF LOUISVILLE

APRIL 27-29, 1977
LOUISVILLE, KENTUCKY

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CO-SPONSORED BY:

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Program Planning, Implementation and Evaluation for Deaf-Blind Children

Kentucky State Deaf-Blind Workshop

Kentucky School for the Blind
Louisville, Kentucky

April 27-29, 1977

DATE									
AGE									
MATURITY LEVEL									
DIAGNOSIS									
MATURITY LEVEL									
DIAGNOSIS									
MATURITY LEVEL									
DIAGNOSIS									
MATURITY LEVEL									
DIAGNOSIS									
MATURITY LEVEL									
DIAGNOSIS									

KEY AGE

4 WEEKS OR LESS
ASYMMETRIC
TONIC-NECK-REFLEX

8 Wee

AREA OF BEHAVIOR	H	O		H	O	
ADAPTIVE	▨		Regard toy only when it is brought in front of eyes	▨		Delayed regard midline over
			Can follow dangled toy only to midline, not past it			Follow dangled *Retain* briefly t
			Drop toy put in hand at once			
GROSS MOTOR	▨		Head sag forward if held *sitting*	▨		Head bob erect
	▨		Asymmetric tonic-neck-reflex postures predominate			No head droop
			Clear nose from bed in prone			*Lift* head to 45 abdomen] re
FINE MOTOR			Both hands held tightly fisted			
	▨		Hand clench as toy touched to it			
LANGUAGE	▨		Impassive face	▨		Alert expressio
	▨		Vague indirect regard	▨		Direct definite
			Make small throaty noises			Make single vo
PERSONAL-SOCIAL	▨		Regard examiner's face and decrease activity			Smile back just and talk to h
	▨		Indefinite stare at surroundings			Eyes follow mo

This inventory is a screening procedure, and a definitive diagnosis should not be made on the basis of a single screening by itself. Some infants identified as deviant by it will require prompt referral to a consultant or a center for a complete diagnostic evaluation. Other deviant infants will require serial observations to determine if such referral is necessary.

REFERENCE TEXT:

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Instructional Films available from the Department of Photography and Cinema, The Ohio State University, Columbus, Ohio 43210.

1. Developmental Evaluation in Infancy.
2. The Gesell Developmental & Neurologic Examination at 16, 28, 40 and 52 Weeks.
3. Normal and Abnormal Neurologic Function in Infancy.

16 Weeks
Toy to Mouth In Supine

28 V
Transfe

36 Weeks

KEY AGE

40 WEEKS
PICKS UP CRUMBS
& THREADS
PLAYS NURSERY TRICKS

44 We

AREA	H	O		H	O		H	O	
ADAPTIVE	▨		Drop one of two toys picked up to take third one offered			Play inside cup with toy you put there, touch and manipulate it			Take toy out o
			Hit toy in hand at toy on table			Hold small toy and try to or pick up crumb at same time			Put small toy i if shown, bu
			Hold toy in one hand and play with attached string with other			Poke with index finger at things	▨		Poke at crumb
GROSS MOTOR			Sit 10 plus minutes steady on *hard surface*			Sit erect and steady indefinitely			Stand at furnit against it, li down
			Stand at furniture and not lean against it if put there			*Go*, not fall, forward to prone			
						Crawl [creep] on hands and knees			
						Pull self to standing			
FINE MOTOR			Pick up small toy in ends of fingers			Put small toy down, take hands off			
			Pick up crumb, thumb and index finger	▨		Pluck crumb up promptly, usually with thumb and index finger			
LANGUAGE			Say da-da, ba-ba, without meaning			Say and mean "ma-ma" and "da-da"			
			Imitate cough, tongue click, etc.			Have one other "word"			
			Know own name			Play nursery trick just if asked			
PERSONAL-SOCIAL			Hold own bottle, pick up if dropped and finish it			Play nursery trick only if you do it first; doesn't understand meaning of words [does above]			Hold out toy t go of it
			Feed self cracker, do good job						Reach for ima

Last Name

First Name

Case #:

Birth Date:

Birth Weight:

E.D.C.:

Days Prematurity Assigned:

READ INSTRUCTIONS

DATE / AGE	AREA OF BEHAVIOR	KEY AGE 4 WEEKS OR LESS ASYMMETRIC TONIC-NECK-REFLEX	8 Weeks	12 Weeks	KEY AGE 16 WEEKS SUPINE REGARDS TOY IN HAND	20 Weeks	24 Weeks	KEY AGE 28 WEEKS SUPPORTED SITTING ONE HAND APPROACH & GRASP	32 Weeks
MATURITY LEVEL DIAGNOSIS	ADAPTIVE	Regard toy only when it is brought in front of eyes Can follow dangled toy only to midline, not past it Drop toy put in hand at once	Delayed regard of toy you held in midline over chest Follow dangled toy past midline *Retain* briefly toy put in hand	Prompt regard of toy dangled in midline at chest level Follow toy, or Ex's hand in 180° continuous arc, side to side Glance at toy when put into hand	Wave arms, move body at sight of toy, dangled if on back, or put on table if held in sitting Regard (look at) toy in hand Take toy to mouth when on back	Bring both hands up towards toy on back or if supported *sitting* Grasp toy only if held near hand (approximately one inch away) Look after toy dropped in sight	Reach and pick up or take toy with both hands Reach for toy dropped within reach Put toy in mouth when held supported in *sitting*	Reach and pick up or take toy with one hand only Transfer toy easily, hand to hand Bang toy up and down when sitting supported	Pick up one small toy and then second one Hold these two prolongedly Secure toy by string if string centered by hand
MATURITY LEVEL DIAGNOSIS	GROSS MOTOR	Head sag forward if held sitting Asymmetric tonic-neck-reflex postures predominate Clear nose from bed in prone	Head bob erect if held sitting No head droop if suspended prone *Lift* head to 45° in prone (on abdomen) recurrently	Head bob forward if held sitting Symmetric posture head, body seen *Hold* head up 45° when in prone (on abdomen) sustainedly	Head steady, set forward, *sitting* Symmetric postures predominate *Hold* head 90°, look directly ahead in prone (on abdomen)	Head erect, steady, held *sitting* No head lag when held by hands and pulled to *sitting* Push whole chest off bed prone	Grasp feet when lying on back (in supine) Roll to abdomen, get both arms out from under chest	Lift head from bed if on back Sit if put on *hard surface* leaning on hands Stand if chest held under arms	Sit 1 minute erect unsteady on *hard surface* Stand, hands held shoulder height Pivot in circle, prone, using arms
MATURITY LEVEL DIAGNOSIS	FINE MOTOR	Both hands held tightly fisted Hand clench on toy touched to it		Hold hands open or close loosely Hold toy put in hand with active grasp	Scratch, finger, clutch at clothes Bring hands together in midline and play with own fingers	Scratch on tabletop or on bed in prone (toy in sight not essential)	Pick up small toy and hold in center of palm with all fingers	Pick up small toy, hold to radial side palm with 2nd and 3rd finger Put whole hand on crumb, rake it	Try to pick up crumb by raking with thumb, 2nd and 3rd fingers usually little arm movement
MATURITY LEVEL DIAGNOSIS	LANGUAGE	Impassive face Vague indirect regard Make small throaty noises	Alert expression Direct definite regard Make single vowels— ah, eh, uh	Coo and chuckle "Talk" back just if you nod head and talk to him	Laugh out loud Excite, breathe heavily, in play	Squeal like a little pig, voice up high	Grunt and growl (deep sounds) Initiate "conversation" with toys or people	Say "Mum mum mum" especially crying Make some vowel sound in series "ah-ah-ah, uh-uh-uh, eh-eh-eh"	Make single consonant sounds, "da, ba, ga, ka"
MATURITY LEVEL DIAGNOSIS	PERSONAL-SOCIAL	Regard examiner's face and decrease activity Indefinite stare at surroundings	Smile back just if you nod head and talk to him Eyes follow moving person around	Look at examiner predominantly Hold up and look at own hand Pull at clothes	Initiate smile just when people come up and stand beside him Recognize bottle just on sight	Smile at self if *close* to mirror Put both hands on bottle when feeding	Know strangers from family Smile and talk to self if put *close* to mirror	Feet to mouth when lying on back Reach out and pat self if put *close* to mirror	Bite and chew toys, not just lick Persist in reaching for toys out of reach

H = HISTORY

O = OBSERVATION

DIAGNOSTIC CATEGORIES:

N = Normal or Advanced
O = Questionable
A = Abnormal

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3 Normal and Abnormal Neurologic Function in Infancy

16 Weeks
Toy to Mouth in Supine

28 Weeks
Transfer Objects

40 Weeks
Index Finger Poking

52 Weeks
Dangles Toy by Its String

15 Months
Builds Tower of Two

18 Months
Scribbles Spontaneously

Last Name

First Name

Case #

Birth Date

Birth Weight

E D C

Days Prematurity Assigned

AREA	36 Weeks	KEY AGE 40 WEEKS PICKS UP CRUMBS & THREADS PLAYS NURSERY TRICKS	44 Weeks	48 Weeks	KEY AGE 52 WEEKS TRIES TO PILE OBJECTS GIVES TOY ON REQUEST	56 Weeks	15 Months	KEY AGE 18 MONTHS LOOKS SELECTIVELY AT AND IDENTIFIES PICTURES	DATE / AGE
ADAPTIVE	Drop one of two toys picked up to take third one offered Hit toy in hand at toy on table Hold toy in one hand and play with attached string with other	Play inside cup with toy you put there, touch and manipulate it Hold small toy and try to or pick up crumb at same time Poke with index finger at things	Take toy out of box or cup Put small toy inside cup or box if shown, but not let go of it Poke at crumb inside bottle	Play with one toy after another of a group in same way, in sequence (e.g. drop to floor, move to another spot on table) Exploit crumb only, ignore bottle	Try piling one small toy on 2nd just presses or it falls off Put toy in cup or box if you show him first each time Dangle toy by string, deliberate	Put toy into cup or box just if you point and ask him to Imitate scribble with crayon after you do it	Pile 1 small toy on 2nd (tower 2) Get 5-6 (of 10) small toys in cup or box, doesn't put all 10 in Stroke crayon *in air* imitatively after you draw vertical stroke	Dump crumb out of bottle—may show Scribble when you hand him crayon, i.e. spontaneously Imitate stroke *on paper* after you draw vertical stroke	MATURITY LEVEL DIAGNOSIS
GROSS MOTOR	Sit 10 plus minutes steady on *hard surface* Stand at furniture and not lean against it if put there	Sit erect and steady indefinitely *Go* not fall forward to prone Crawl (creep) on hands and knees Pull self to standing	Stand at furniture without leaning against it, lift one foot up and down	Hold furniture and walk around it Walk if both hands held at shoulder height for balance	Walk with only one hand held	Forget to hold on, stand alone momentarily If standing up take few steps alone, fall headlong	No longer creep or crawl Get up in middle of floor and walk alone Collapse and catch self when falls	Run stiff legged Rarely fall when walking Climb into adult chair *Walk* upstairs if you hold one hand	MATURITY LEVEL DIAGNOSIS
FINE MOTOR	Pick up small toy in ends of fingers Pick up crumb, thumb and index finger	Put small toy down, take hands off Pluck crumb up promptly, usually with thumb and index finger		Pluck crumb easily with thumb and index finger, not resting arm or hand on tabletop		Pick up two small toys in one hand at same time deliberately	Drop crumb into bottle just if you point and ask him to *Help* turn pages of book	Turn pages of book 2-3 at once Stack up 3 small toys (tower 3)	MATURITY LEVEL DIAGNOSIS
LANGUAGE	Say da-da, ba-ba without meaning Imitate cough, tongue click etc Know own name	Say and mean "ma-ma" and "da-da" Have one other "word" Play nursery trick just if asked			Say 2 words plus ma-ma and da-da *Let go* of toy into your hand if you hold hand out for it	Say 3 or 4 words When asked to, look at objects: ball, shoe, light, T-V set, etc.	4-6 words, including first names "Talk" foreign language—jargon Pat at pictures in book	Point to picture, if ask dog baby Look back and forth as you point from 1 picture to other in book	MATURITY LEVEL DIAGNOSIS
PERSONAL-SOCIAL	Hold own bottle, pick up if dropped and finish it Feed self cracker, do good job	Play nursery trick only if you do it first, doesn't understand meaning of words (does above)	Hold out toy to you, but not let go of it Reach for image of toy in mirror	Take toys off table to another surface (e.g. floor) deliberately in play	Help in dressing-push arm thru sleeve if you get it started Offer toy to own mirror image	Use slight tossing motion and play ball with you, throwing it towards you	Indicate wants by pointing or vocalizing (grunt, "uh-uh-uh") When fed leaves dish on tray	Walk or crawl, pulling string toy Hug and love doll, stuffed animal Use spoon to feed, spill good bit	MATURITY LEVEL DIAGNOSIS

READ INSTRUCTIONS   READ INSTRUCTIONS   READ INSTRUCTIONS

eks	H	O	12 Weeks	H	O	KEY AGE 16 WEEKS SUPINE REGARDS TOY IN HAND	H	O	20 Weeks	H	O	
of toy you hold in chest	▨		Prompt regard of toy dangled in midline at chest level			Wave arms, move body at sight of toy; dangled if on back, or put on table if held in sitting			Bring both hands up towards toy, on back or if supported *sitting*			Reac w
toy past midline	▨		Follow toy, or Ex's hand, in 180° continuous arc, side to side			Regard [look at] toy in hand			Grasp toy only if held near hand [approximately one inch away]			Reach
y put in hand			Glance at toy when put into hand			Take toy to mouth when on back			Look after toy dropped in sight			Put su
if held *sitting*	▨		Head bob forward if held *sitting*			Head steady, set forward, *sitting*	▨		Head erect, steady, held *sitting*			Gros [i
if suspended prone	▨		Symmetric posture head, body seen	▨		Symmetric postures predominate	▨		No head lag when held by hands and pulled to *sitting*			Roll ou
° in prone [on currently			*Hold* head up 45° when in prone [on abdomen] sustainedly			*Hold* head 90°, look directly ahead in prone [on abdomen]			Push whole chest off bed, prone			
			Hold hands open or close loosely			Scratch, finger, clutch at clothes	▨		Scratch on tabletop, or on bed in prone [toy in sight not essential]			Pick ce
	▨		Hold toy put in hand with active grasp			Bring hands together in midline and play with own fingers	▨					
			Coo and chuckle			Laugh out loud			Squeal like a little pig, voice up high			Gru
egard vels—"ah, eh, uh"			"Talk" back just if you nod head and talk to him	▨		Excite, breathe heavily, in play						Initi o
if you nod head im	▨		Look at examiner predominantly			Initiate smile just when people come up and stand beside him			Smile at self if *close* to mirror			Kno
ing person around			Hold up and look at own hand			Recognize bottle just on sight			Put both hands on bottle when feeding			Smil *cl*
			Pull at clothes									

Veeks
Objects

40 Weeks
Index Finger Poking

52 Weeks
Dangles Toy by Its String

B

eeks	H	O	48 Weeks	H	O	KEY AGE 52 WEEKS TRIES TO PILE OBJECTS GIVES TOY ON REQUEST	H	O	56 Weeks	H	O	
box or cup			Play with one toy after another of a group in same way, in sequence [e.g., drop to floor, move to another spot on table]			Try piling one small toy on 2nd just presses or it falls off	▨		Put toy into cup or box just if you point and ask him to			Pile
side cup or box not let go of it						Put toy in cup or box if you show him first each time			Imitate scribble with crayon after you do it			Get o
inside bottle	▨		Exploit crumb only, ignore bottle			Dangle toy by string, deliberate				▨		Stra a
ure without leaning t one foot up and			Hold furniture and walk around it			Walk with only one hand held			Forget to hold on, stand alone momentarily			No
			Walk if both hands held at shoulder height for balance						If standing up, take few steps alone, fall headlong			Get w
												Col
	▨		Pluck crumb easily with thumb and index finger, not resting arm or hand on tabletop				▨		Pick up two small toys in one hand at same time, deliberately			Dro p
												Hel
						Say 2 "words" plus ma-ma and da-da			Say 3 or 4 "words"			4-6
						Let go of toy into your hand if you hold hand out for it			When asked to, look at object: ball, shoe, light, T-V set, etc.			"Ta
												Pat
you, but not let			Take toys off table to another surface [e.g., floor] deliberately in play			Help in dressing-push arm thru sleeve if you get it started			Use slight casting motion and play ball *with* you, throwing it towards you			Ind v
e of toy in mirror						Offer toy to own mirror image						Wh

READ INSTRUCTIONS

CHILD BY CHILD PLANNING

"WHO"

Personnel Involved:
- Parents
- Teachers
- Aides
- P.T.
- O.T.
- Speech Therapist
- Mobility Instructor

"WHAT IS"

Resources to use:
- Medical records
- Developmental scales
- Diagnostic classroom assessments
- Parent reports

"WHAT SHOULD BE"

Establish the Need:

1. Long Range Goals

   * identify end results sought
   * establish overall orientation and direction

2. Objectives

   * more closely defined goals, but still too general for daily use.

3. Strategies

   * identify how the objectives will be met, step by step plans.

EXAMPLE:

Long Range Goal: Independent Dressing

Objective: Take off pants

Strategies:
1. Pull pants off one leg at ankle height.
2. Pull pants off one leg at knee height.
3. Pull pants off both legs at ankle height.
4. Pull pants off legs, knee height.
5. Etc.

Deaf-Blind Child Plan

Jose Santiago January 1, 1977 PRIDE for Deaf-Blind

I. Developmental Area: Self Help Skills

A. Goal: To increase Jose's proficiency in self help skills.

B. Objective: To chew semi-solid foods: cottage cheese, mashed bananas.

C. Strategies:
1. Manipulate jaws in an up and down direction to create a chewing motion.
2. Massage gums to stimulate a chewing response.
3. Feed the child only semi-sold foods for consistentcy.
4. Reward any chewing motion with liquids.

II. Developmental Area: Sensory Stimulation

A. Goal: To increase Jose's tactile/kinesthetic/visual awareness of self by use of sensory channels.

B. Objective: To stimulate Jose'using a variety of textures that will increase body awareness and sensory feedback to the central nervous system.

C. Strategies:

1. Strip Jose down to diaper.
2. Rub a variety of textures, lotions, and creams on his body.
3. Talk to Jose constantly, explaining the different textures being applied.
4. Reward any vocalizations with social reinforcers.

D. Objective: to develop maximum use of Jose's residual hearing and localization of sound.

E. Strategies:

1. Present a sound source to Jose (i.e. a bell)
2. Ring the bell on right and left side of head
3. Identify the sound, say "bell"
4. Help Jose turn his head to the sound source
5. Place the bell in Jose's hand and ring it close to his ear.

F. Objective: to develop training in visual attention and tracking.

G. Strategies:

1. Hang a brightly colored mobile over Jose's crib and playpen.
2. Move objects slowly back and forth, up and down, in circular motions in front of him so that he can learn to follow objects with his eyes.
3. Allow Jose to grasp objects in visual field for reinforcement.

III. Developmental Area: Motor Development

A. Goal: to develop and improve Jose's gross motor skills.

B. Objective: To enable Jose to roll over.

C. Strategies:

1. Roll Jose in a blanket.
2. Slowly roll him out of a blanket.
3. Place Jose in a supine position.
4. Lift his right arm acrosss midline and over head giving some resistance to hip until rotation occurs
5. Allow complation of roll through Jose's righting of his body.

IV. Developmental Area: Adaptive/Social

A. Goal: To develop in the perception of relationships.

B. Objectives: Jose will perceive relationships between cues and people.

C. Strag^tegies:

1. Identify yourself to Jose each day in the same way.
2. Pair the same phrase with a special signal so Jose will know it is you. (i.e. say, "What's happening, Jose?" with a kiss on the nose).
3. Jose will associate specific signs or cues for specific people.

D. Objective: Jose will grow in positive interactions with humans.

E. Strategies:

1. Hold Jose close to your face and talk to him.
2. Encourage him to touch your face by placing his hands on your face.

PATIENT CARE PLAN
Interdisciplinary

Patient Name______________________________Physician______________________________________

Record No.____________Admission Date:______________Age:________Sex:___________________

DIAGNOSIS:

Prognosis for each diagnosis specify (Good 1), (Poor 2), (Guarded 3)

Attending Physicians Care Plan:

Nursing Care Plan:

Physical Therapy Care Plan:

Speech Therapy Care Plan:

Occupational Therapy Care Plan:

Dental Care Plan:

Optometrist:

Psychological Care Plan:

Educational Care Plan:

Activities Care Plan:

Social Care Plan

Consult-ants Care Plan Physician ( ) Others ( ) Specify__________

Interdisciplinary Care Plan:

Short Term:

Long Term:

(Include discharge potential) Good - 1, Poor - 2, Guarded - 3
Discharge to SCU_________ Discharge - ICU_____________
Discharge to Home_________ Discharge - Other (specify)_________

Authorization for implementation of
Patient Care Plan

INDIVIDUAL INSTRUCTIONAL PLAN

Area of Instruction____________________ Birthdate__________

Name____________________ Teacher__________

Date Initiated:__________ Date Completed:__________

BEHAVIORAL OBSERVATION:

Instructional Goals: To instruct the child in...

1.____________________

2.____________________

3.____________________

Behavioral Objectives for Child:

A. The child will be able to:____________________

B. The child will be able to:____________________

C. The child will be able to:____________________

METHODS AND MATERIALS

1.____________________

____

2.____________________

____

3.____________________

____

EVALUATION OF METHODS AND MATERIALS

____

____

EVALUATION OF PROGRESS

	Achieved	Made Progress	Dropped	Modified
Goal A				
Goal B				
Goal C				

Educationl Plan

Name of Child____________________ Date Submitted__________

Date of Birth__________ Age____ Yrs.____ Mos.____ Attendance________

Teacher________________ Lower School Level

Self-Help Skills

Feeding, Eating, And Drinking (BCP 3,4,31)

Observation:

Plan:________will be able to: 1.____________________

2.____________________

3.____________________

Toileting and Grooming (BCP 5,6)

Observation:

Plan:________will be able to: 1.____________________

2.____________________

3.____________________

Dressing and Undressing (BCP 7,8)

Observation:

Plan:________will be able to: 1.____________________

2.____________________

3.____________________

Nasal and Oral Hygiene (BCP 9,10)

Observation:

Plan:________will be able to: 1.____________________

2.____________________

3.____________________

Perceptual and Motor Skills

Sensory Perception (BCP 12)

Observation:

Plan________will be able to: 1.____________________

2.____________________

3.____________________

Auditory Perception (BCP 13)

Observation:

Plan:__________will be able to: 1.____

2.____

3.____

Visual Motor (BCP 14,15) Fine Motor

Observation:

Plan:__________will be able to: 1.____

2.____

3.____

Gross Motor (BCP 16,17,54,56)

Observation:

Plan:__________will be able to: 1.____

2.____

3.____

Self-Identification and CO-Active Movement (BCP 11)

Observation:

Plan:__________will be able to: 1.____

2.____

3.____

ADDITIONAL COMMENTS:

TARGET SPECIFIC PLAN
(limited to one target behavior only)

Name________________________________ Number____________ ELC_________________

Date of Implementation:

Present Behavior Strengths	Target Behaviors

Target Behavior Goals	Deadline Date	Methods to be used & Person Responsible

Signed______________________

INDIVIDUAL PROGRAM PLAN

Goals	Strategy Procedures	Materials	Evaluation

Child-by-Child Planning Cards

Front

Student's Name________________________ Date________________________

Subject______________________________

Student goals:

Activities	Mon.	Tue.	Wed.	Thurs.	Fri.

Back

Comments:

Alternative Activities:

Actual size of cards - 5" x 8"

Code used on the cards: More than one from each column can be used.

1 - Completed task - Independent
2 - Completed task - Assisted
3 - Task not completed
4 -4Task too difficult

a - Appropriate behavior
b - Did not attend to task
c - Lack of cooperation
d - Tantrum

Scales and
Tests

munication

Behaviors

Auditory

Motor

Visual

elf-Help

Use of Developmental Scales and Tests

Kitty Mitchell

Callier-Azusa Scale

Fiorentino Reflex Testing Method for Evaluating CNS Development

Learning Accomplishment Profile (LAP)

Portage Project

Wabash Developmental Guide for Early Developmental Training

Nonverbal Developmental Screening Inventory

Peabody Inner Language Scale

Peabody Manual of Self-Help Skills

Peabody Developmental Motor Skills

Receptive-Expressive Emergent Language Scale

Language Acquisition Program for the Retarded or Multiply Handicapped

Sequenced Inventory of Communication Development (SICD)

A Training Guide to Mobility and Orientation in Young Multihandicapped Blind Children

A Vision Guide for Teachers of Deaf-Blind Children

SOUTHEAST REGIONAL CENTER FOR DEAF-BLIND CHILDREN

CHILD-BY-CHILD COMMITTEE

FALL, 1975

IDENTIFIED EVALUATIVE INSTRUMENTS

GENERAL ASSESSMENT

Bayler Scales of Infant Development
  Nancy Bayler
  The Psychological Corporation
  304 E. 45th Street
  New York, N. Y. 10017

Behavioral Characteristics Progression
  Santa Cruz County Office of Edu.
  Vort Corporation
  Publications Dept. D
  P. O. Box 11132
  Palo Alto, Calif. 94306

Callier-Azusa Scale
  Callier Center for Communication Disorders
  1966 Inwood Road
  Dallas, Texas 75235

Cattell Infant Intelligence Scale
  P. Cattell
  Psychological Corporation
  304 E. 45th Street
  New York, N. Y. 10017

Denver Developmental Screening Test
  W. Frankenburg, et al.
  Ladoca Project & Publ. Found.
  E. 51st & Lincoln Street
  Denver, Colorado 80216

Developmental Potential of Preschool Children: An Evaluation of Intellectual, Sensory and Emotional Functioning
  E. Haeusserman
  Grune & Stratton
  381 Park Avenue, South
  New York, N. Y. 10016

Ellisville State School Assessment
  Mississippi Deaf-Blind Evaluation Center
  Ellisville State School
  Ellisville, Mississippi 39437

Georgia Academy for the Blind Checklist
  Georgia Academy for the Blind
  Macon, Georgia

Georgia Center for the Multi-Handicapped Assessment Scales
  2040 Ridgewood, N. E.
  Atlanta, GA 30307

Gesell Developmental Schedules
  A. Gesell, et al.
  Psychological Corporation
  304 E. 45th Street
  New York, N. Y. 10017

(1) Learning Accomplishment Profile;
(2) Infant Learning Accomplishment Profile
  Ann Sanford
  Chapel Hill Training-Outreach Project
  Lincoln Center
  Chapel Hill, N. Carolina

Manual for the Assessment of a "Deaf-Blind" Multihandicapped Child
  M. Collins & J. Rudolph
  Michigan School for the Blind
  Deaf-Blind Department
  715 Willow Street
  Lansing, Michigan 48906

Prescriptive Teaching Program for Multiply Handicapped Nursery School Children: Skills Sequence Checklist
  Mayer Children's Rehabilitation Institute
  University of Nebraska Medical Center
  Omaha, Nebraska

The Portage Guide to Early Education: Instructions and Checklist (Experimental Edition)
D. Shearer, et al.
Cooperative Educational Service Agency #12
Portage, Wisconsin 53701

Preschool Attainment Record, Research Edition (PAR)
Edgar A. Doll
American Guidance Service, Inc.
Publisher's Bldg.
Circle Pines, Minn. 55014

Pupil Record of Educational Behavior
Teaching Resources Corporation
100 Boylston
Boston, Mass. 02116

Topeka Assn. for Retarded Children Assessment Inventory (TARC)
H & H Enterprises
P. O. Box 3342
Lawrence, Kansas 66044

Wabash Developmental Guide for Early Developmental Training
Wabash Center
2000 Greenbush
Lafayette, Ind. 47904

Crittenden Assessment Checklist for Multiply Handicapped Deaf-Blind Children
A. Rae Crittenden
Hillsborough County Public Schools
Tampa, FL 33602

SCREENING

Manual for the Deaf-Blind Program and Ability Screening Test
J. Lyall, V. Henry, G. Graham, and S. Lassiter
Mississippi Deaf-Blind Evaluation Center
Ellisville State School
Ellisville, Miss. 39437

Developmental Activities Screening Inventory (Experimental Edition)
Rebecca DuBose
George Peabody College for Teachers
Nashville, Tenn. 37203

Screening Questionnaire for Deaf-Blind Children under Residential Care
Perkins School for the Blind
Department for Deaf-Blind Children
Watertown, Mass. 02172

COMMUNICATION

Illinois Test of Psycholinguistic Ability (ITPA)
J. McCarthy & S. Kirk
University of Illinois Press
Urbana, Illinois

Inner Language Scale
M. Branston & R. DuBose
George Peabody College for Teachers
Nashville, Tenn. 37203

The Preschool Language Scale
I. L. Zimmerman, V. Steiner & R. Evatt
Charles E. Merrill Publ. Co.
Columbus, Ohio 43201

The Receptive Expressive Emergent Language Scale (REEL)
K. Bzoch & R. League
Tree of Life Press
Gainesville, FL 32601

SELF-HELP SKILLS

Manual for Development of Self-Help Skills in Multiple Handicapped Children
George Peabody College for Teachers
Nashville, Tenn. 37203

Oak Hill
(No further information available)

COGNITION

Columbia Mental Maturity Scale
L. Blum, B. Burgemeister & I. Lorge
Harcourt, Brace & Javanovich, Inc.
New York, N. Y.

Joseph French Pictorial Test of Intelligence
Houghton Mifflin
53 W. 43rd Street
New York, N. Y. 10036

Hayes-Binet
(Adaptation of the Stanford-Binet for the Visually Impaired)
Perkins School for the Blind
175 N. Beacon Street
Watertown, Mass. 02172

Hiskey-Nebraska Test of Learning Aptitude
M. S. Hiskey
5640 Baldwin
Lincoln, Nebraska 68508

Leiter International Performance Scale
R. Leiter & G. Arthur
Stoelting Company
1350 S. Kostner Ave.
Chicago, Ill. 60623

McCarthy Scales of Children's Abilities
D. McCarthy
Psychological Corporation
304 E. 45th Street
New York, N. Y. 10017

Merrill-Palmer Scale of Mental Tests
R. Stutsman
Stoelting Company
1350 S. Kostner Avenue
Chicago, Illinois 60623

Ontario School Ability Examination
H. Amoss
Ryerson Press
299 Queen Street, West
Toronto 2B
Ontario, Canada

Standford Binet Intelligence Scale
L. Terman & M. Merrill
Houghton Mifflin Co.
100 Tremont Street
Boston, Mass. 02107

Wechsler Adult Intelligence Scale
D. Wechsler
Psychological Corporation
304 E. 45th Street
New York, N. Y. 10017

Wechsler Intelligence Scales for Children
D. Wechsler
Psychological Corporation
304 E. 45th Street
New York, N. Y. 10017

Wechsler Preschool and Primary Scales of Intelligence
D. Wechsler
Psychological Corporation
304 E. 45th Street
New York, N. Y. 10017

SOCIAL-EMOTIONAL

Maxfield-Buchholz; Scale of Social Maturity for Use with Preschool Blind Children
K. Maxfield & S. Buchholz
American Foundation for the Blind, Inc.
15 W. 16th Street
New York, N. Y. 10011

Vineland Social Maturity Scale
E. Doll
American Guidance Service
Circle Pines, Minn. 55014

SENSORY/SENSORY-MOTOR

Marianne Frostig Developmental Test of Visual Perception
M. Frostig, et al.
Consulting Psychologist Press
577 College Avenue
Palo Alto, Calif. 94306

Manual for Visual Assessment Kit
C. Ficociello
Area Center for Services to Deaf-Blind Children
Callier Center for Communication Disorders
1966 Inwood Road
Dallas, Texas 75235

Operant Audiometry Manual for Difficult-to-Test Children
D. Bricker, W. Bricker & L. Larsen
Institute of Mental Retardation and Intellectual Development
George Peabody College for Teachers
Nashville, Tenn. 37203

A Vision Guide for Teachers of Deaf-Blind Children
M. Efron & B. DuBoff
Special Education Instructional Materials Development Center
Division for Exceptional Children
Department of Public Instruction
Raleigh, N. Carolina

Visual Efficiency Scale
N. Barraga
American Printing House for the Blind
Louisville, Kentucky 40501

MOTOR/PHYSICAL

Lincoln-Oseretsky Motor Development Scale
W. Sloan
Stoelting Company
1350 S. Kostner Avenue
Chicago, Ill. 60623

Frostig Motor Skills Test
M. Frostig, et al.
Consulting Psychologists Press
577 College Avenue
Palo Alto, Calif. 94306

Peabody Developmental Motor Scales
R. Folio & R. DuBose
John F. Kennedy Center
George Peabody College for Teachers
Nashville, Tenn. 37203

ACADEMIC

Key Math Diagnostic Arithmetic Test
A. Connolly, et al.
American Guidance Service, Inc.
Publisher's Building
Circle Press, Minn. 55014

Metropolitan Achievement Tests
(Several different batteries)
W. Durost, et al.
Harcourt, Brace & Jovanovich, Inc.
757 Third Avenue
New York, N. Y. 10017

Peabody Individual Achievement Test
L. Dunn, et al.
American Guidance Sercice, Inc.
Publisher's Building
Circle Press, Minn. 55014

Stanford Achievement
(No further information available)

Communication

Behaviors

Auditory

Motor

Visual

elf-Help

Language Development and Communication

I. Sequence of Development

  A. Developmental Language Charts
  B. Pre-language
  C. Receptive
    1. Commands
    2. Actions
    3. Names
  D. Expressive
    1. Yes, No
    2. Names
    3. Structure

II. Methods of Presentation
  A. Simplicity
    1. Clear, precise
    2. Confined to kernal sentences
  B. Constant Stimulation

III. Sign Language - Communication
  A. Why it is used
    1. Concrete language
    2. Tactile
    3. Basic Conceptual
  B. Methods of Presentation
    1. For partially sighted child
    2. For Totally Blind child
  C. References for accuracy

Figure 1
MODEL FOR TEACHING COMMUNICATION AS A DEVELOPMENTAL PROCESS

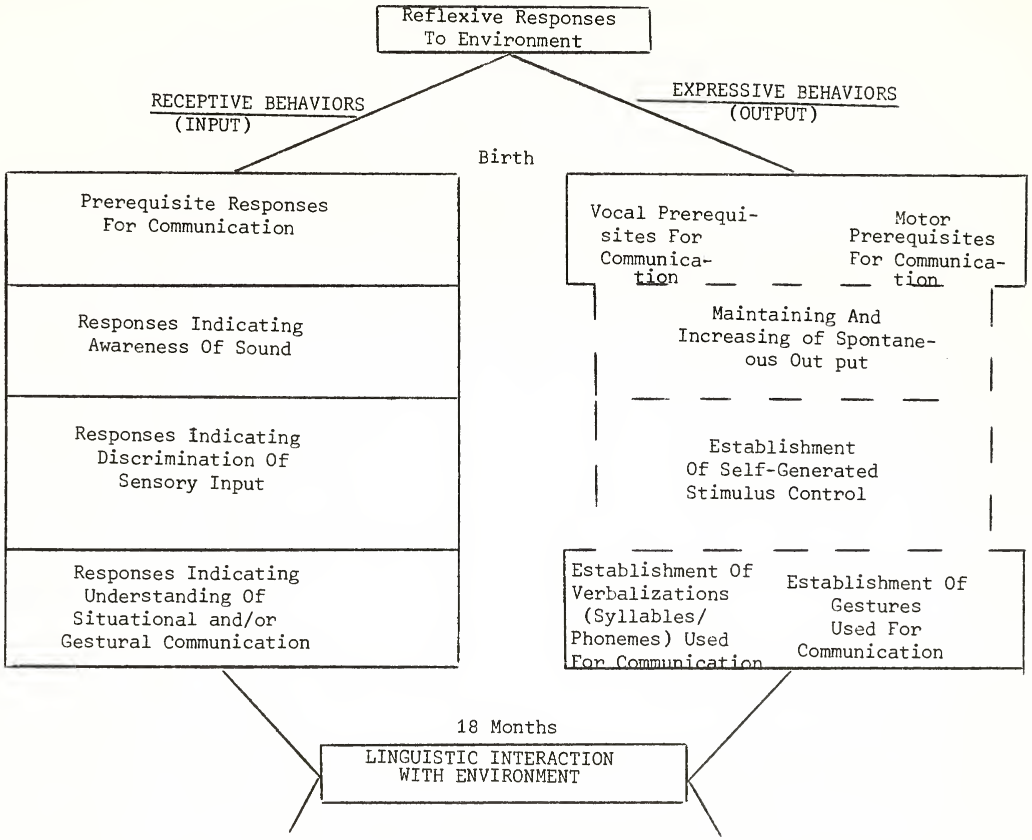
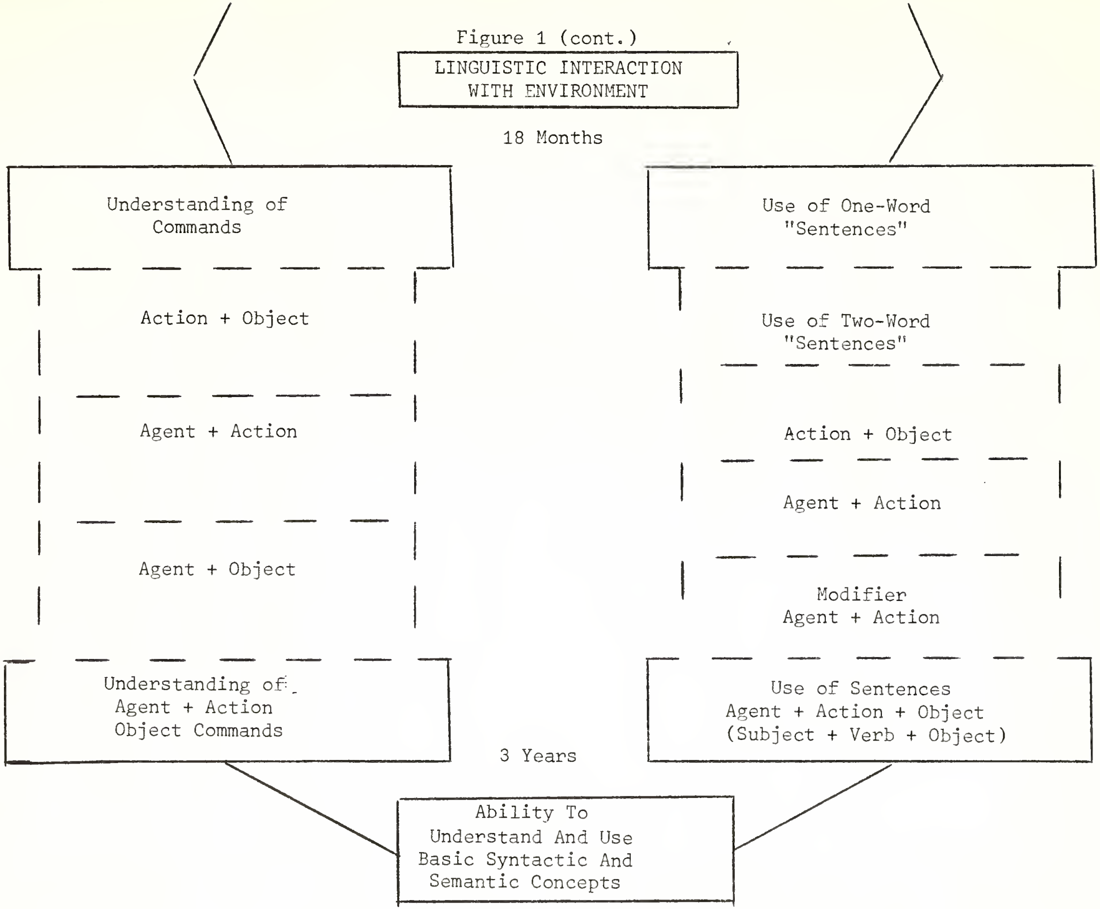

Reflexive Responses To Environment
RECEPTIVE BEHAVIORS (INPUT)
EXPRESSIVE BEHAVIORS (OUTPUT)
Birth
Prerequisite Responses For Communication
Responses Indicating Awareness Of Sound
Responses Indicating Discrimination Of Sensory Input
Responses Indicating Understanding Of Situational and/or Gestural Communication
Vocal Prerequisites For Communication
Motor Prerequisites For Communication
Maintaining And Increasing of Spontaneous Out put
Establishment Of Self-Generated Stimulus Control
Establishment Of Verbalizations (Syllables/ Phonemes) Used For Communication
Establishment Of Gestures Used For Communication
18 Months
LINGUISTIC INTERACTION WITH ENVIRONMENT

Figure 1 (cont.)



LANGUAGE AWARENESS AND THE DEAF-BLIND CHILD

Ann Kennedy

Lenneberg has pointed out that negative effects of sensory deprivation are multiplicative (Lenneberg, 1967). The deficit from one handicap cannot be substracted from the functioning or experience of an individual because other aspects are affected. Substract hearing and the individual is also affected in interpersonal relationships, knowledge acquisition, and frustration in daily living.

The impact of multihandicaps is not simply additive. Specifically, the summed effects of blindness and deafness together are far more detrimental than the effects of deafness and blindness occuring separately, particularly where one sense is used to compensate for the other when only one of the handicaps exists.

The basic difference in beginning language teaching with a deaf-blind child in contrast to a child who is either deaf or blind is that the multiply handicapped youngster has no concept of the function of language. The deaf child can see people communicating. He can also see the effects of communication. He sees people call each other and turn around. He sees Mother point to the bag of groceries in the car - move her lips a bit, and sees Father pick up the bag, and walk into the house. The whole process may seem somewhat magical but when training in language is started the possibilities become apparent.

The blind child, of course, hears communication as a normal child, and although he cannot observe many of the physical effects, there are enough opportunities available for him to understand the idea of language as a maniplative device. For example, Mother calls to Father, "Bring me Johnny's coat." The next moment Father walks in saying "Here it is" and the child feels himself being wrapped in his coat. Both the deaf child and the blind child therefore develop a concept of the utility of communication, but how can we motivate the deaf-blind child who possibly has no awareness of language?

ESSENTIALS OF THE LANGUAGE PROGRAM

The language program for the deaf-blind child should include the following essential components:

1. Developing awareness of communication and a concept of the purpose and function of language.

2. Motivating the children to participate in communication activities.

3. Consistent behavior by attendant adults to the spontaneous attempts by the children to communicate.

4. Varied opportunities for the child to develop cognitive skills through play materials and structured manipulative tasks.

5. Structured language activities designed to lead the child through stages of labeling and using sentence patterns into progressive levels of child grammars.

The terms word and sign are used interchangeable in the descriptions of teaching suggestions which follow because the decision has to be taken with each child whether to place major emphasis on the use of residual hearing, with or without visual assistance, or on sign language (if the child has sufficient vision to perceive signs), or on a form of fingerspelling which he can feel. From a psycholinguistice viewpoint, the choice among modes is not significant. Provided a specific symbol is consistently used so that it becomes a part of the child's repertoire, language growth can proceed because he can thereafter manipulate the symbols according to his developing rule system. The American Sign Language was primarily used in the activities discussed here; however, certain signs were invented for the children's fovorite toys and other objects for which there are no recognized signs.

The essential points to consider when deciding on the modes are:

1. Through which mode will there be most imput?

2. By which mode will the child be able to function earliest?

All possible situations should be used to stress the function of language with particular attention to those situations which occur naturally with a high level of meaningfulness for the child. Also, situations must be contrived in which it is demonstrated to the child that language is a tool worth using.

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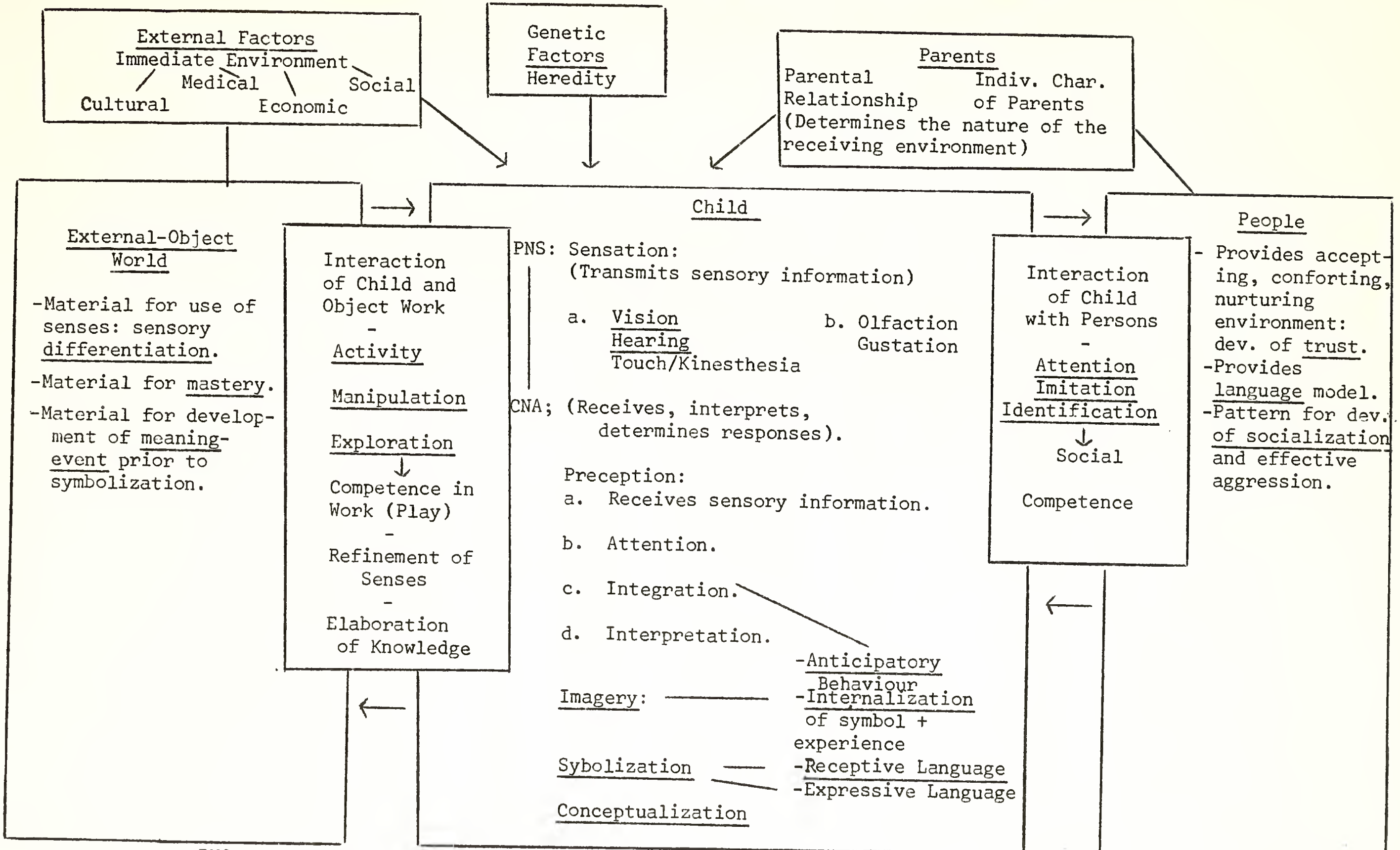
Education, Interprovincial School
for the Deaf, Amherst, Nova Scotia,
Canada.

Excerpt from - TEACHING EXCAPTIONAL
CHILDREN - WINTER 1974

AREAS OF POSSIBLE INTERFERENCE WITH NORMAL DEVELOPMENT OF LANGUAGE


External Factors
Immediate Environment
Cultural
Medical
Economic
Social
Genetic Factors
Heredity
Parents
Parental Relationship
Indiv. Char. of Parents
(Determines the nature of the receiving environment)
External-Object World
-Material for use of senses: sensory differentiation.
-Material for mastery.
-Material for development of meaning-event prior to symbolization.
Interaction of Child and Object Work
-
Activity
Manipulation
Exploration
Competence in Work (Play)
-
Refinement of Senses
-
Elaboration of Knowledge
Child
PNS: Sensation:
(Transmits sensory information)
a. Vision
Hearing
Touch/Kinesthesia
b. Olfaction
Gustation
CNA; (Receives, interprets, determines responses).
Preception:
a. Receives sensory information.
b. Attention.
c. Integration.
d. Interpretation.
Imagery:
Sybolization
Conceptualization
-Anticipatory Behaviour
-Internalization of symbol + experience
-Receptive Language
-Expressive Language
Interaction of Child with Persons
-
Attention
Imitation
Identification
Social
Competence
People
- Provides accepting, conforting, nurturing environment: dev. of trust.
-Provides language model.
-Pattern for dev. of socialization and effective aggression.

PNS - Peripheral Vervous System

CNS - Central Nervous System

LIMITED BIBLIOGRAPHY

Sign Language Books

Deafness Research and Training Center, New York University. Modified Manual Communication for Deaf Blind Children. $5.00.

Babbini, Barbara. Manual Communication: Fingerspelling and the Language of Sign. $5.00.

David, A. The Language of Signs. $4.59.

Fant, Lou J., Jr. Ameslan: An Introduction to American Sign Language. $4.95.

Gustason, G., Pfretzing, D. and Zawolknow, E. Signing Exact English. $13.50.

Huffman, Jeanne, et al. Talk With Me. (Specifically for the multihandicapped deaf child.) $14.95

O'Rourke, Terrence. A Basic Course in Manual Communication. $5.20.

Riekehof, Lottie L. Talk to the Deaf. $4.95

Watson, David O. Talk With Your Hands. $5.00.

Language Development

Foster, E., Levy, J., and Cullison, S. Let the Sunshine In! Part I, $3.50, Part II, $4.50.

Furth, Hans G. Thinking Without Language. $8.95.

Mikalonis, Huffman, Gaddy, Gillis, Heater. Leisure Time Activities for Deaf-Blind Children. $12.95.

Any of the books listed above may be ordered from the Gallaudet College Bookstore, Washington, D. C. 20002.

Behaviors

Auditory

Motor

Visual

elf-Help

Learning Sequences

Dealing With Behaviors,
Behavior Modification and
Pre-academic Curriculum

Presentor - Sara Walsh

I. Slide Presentation
Pointing out pertinent facts about working with deaf-blind children, specific behaviors, and a preacademic curriculum.

II. Behavior Modification:
How not to use it.
How to initiate a behavior modification program: including - isolating behaviors to be modified.
Discussion on the ability to transfer learning to other environments.

III. Questions from the participants

Time Permitting - Discussion on task analysis

Learning Sequences

There have been some children who have gone through the evaluation center on whom it was difficult to get a developmental age in the area of language. With these children "Learning Sequences" were outlined and followed in order to determine the child's ability to learn simple tasks. From the response and level of achievement made on the learning sequence a determination could be made as to the ability of the child. It would answer such questions as:

1. Are the child's disabilities retarding his development or is mental retardation the causative factor?
2. Can the child learn if correct learning modality is found and employed?
3. If the child does the task - "How long did it take for success?"

Two sample learning sequences follow.

Learning Sequence

Subject: Yvette

Length of Time Observed and Taught: Two weeks

History:

Age: 6 years

Ophthalmological evaluation: No functional vision
Light perception in left eye

Audiological evaluation: Profoundly deaf

Neurological evaluation: Rubella Syndrome
Microcephalic
Self-care skills obtainable

Pediatric evaluation: Congenital Rubella Syndrome
Cataracts
Status Post Cataract Surgery (right eye)
Visual Impairment
Hearing Impairment
Pes Planus bilaterally
Heart Murmur, etiology undetermined
Microcephaly
Microphthalmia in the right eye

Global Ocjective: To teach Yvette to reproduce one speech sound - "ah" - by means of the Tadoma (Vibration) Method of teaching speech.

Yvette is a profoundly deaf child with no functional vision. She has no speech. Her learning modality is 'tactual." The teacher decided to captialize on her tactual ability in the teaching sequence.

Lesson I

Object: To get Yvette to accept a headset

Yvette had found a large rag doll in the classroom and it was evident she recognized it to be a doll and liked it. She would undress the doll and put it in the doll bed.

Being cognizant that Yvette had never been introduced to a head, the teacher brought the doll to the teaching station, placed the headset on the doll's head and let Yvette explore the doll's head and the headset on it. The teacher removed the headset and let her explore it by itself and then replaced it on the doll's head. This was repeated throughout the 20 minutes.

Result: You could see the curiousity in Yvette's face as she tried to figure out what was on the doll's head. She was not afraid to touch the headset either on or off the doll.

Lesson II

Objective: To get Yvette to wear the headset

This session began with the dollas in Lesson I, then the teacher-put the headset on her head and let Yvette feel it. She was not afraid, so the teacher gently placed it on her head. She accepted it with no hesitancy. The teacher plugged the headset into the amplifier on "low" and said "hi." This was repeated throughout the session with the amplification being increased gradually.

Result: Yvette accepted the headset well. She had a startle response to the sound when it reached the "6" level on the phonic ear. She smiled and became excited. Having established an acceptance of the headset and Yvette now having the benefit of amplification, the teacher proceeded to the next lesson.

proceeded to the next lesson.

Lesson III

Objective: To get Yvette to accept and enjoy placing her hand on the teacher's mouth and throat.

The teacher took Yvette's hand, placed it palm up on her mouth and said "Boo." She smiled. This was repeated several times, then the teacher-touched her hand to see if she would volunteer the movement. She did not. The teacher repeated the motion, moving-Yvette's hand to her (the teacher's) mouth. After about ten tries, the teacher was able to get her to place her hand to her mouth independently.

Results: Yvette became acquainted "tactually" with the teacher. She finally followed through with the desired movement on her own.

Lesson IV

Objective: To get Yvette to place her hands correctly on the teacher's mouth and throat (in order to employ Tadoma (Vibration) Method of teaching speech).

The correct placement of Yvette's hand was demonstrated for her and the teacher immediately sounded a loud "ah" to acquaint her with the vibration of the throat and position of the mouth.

Result: Yvette withdrew her hands immediately, apparently a little afraid of this new experience.

This lesson was repeated for a week with the following results:

Fifth and Sixth Days:

Yvette attempted zo produce the "ah" sound but emitted only a "heavy breath" sound. She was given an M & M for her effort. This became a real turning point in the teaching as Yvette loved this reward. Her effort and interest increased.

Seventh, Eigth, and Ninth Days:

Yvette independently tried to make the sound. The teacher opened and positioned her mouth for her and had her place one of her hands on her own throat and one on the teacher's face (thumb on the teacher's mouth). Yvette slowly progressed to a sort of burping sound in her throat. The M & M reward was given for each effort.

Tenth, Eleventh, and Twelfth Days:

The same method was employed as before, but reward was given only when she opened her mouth properly and emitted a loud sound. The sound was not always the "ah" sound; however, she was rewarded for any loud emission.

Thirteenth and Fourteenth Days:

Time was spent in refining the sound. Yvette was rewarded only if her sound resembled "ah." She was able to respond correctly most of the time.

At the end of the two weeks Yvette was able to anticipate the "teaching session." She went willingly to the teaching station, sat down immediately, placed one of her hands on her throat and reached out the other for the teacher. After each reproduction of "ah" Yvette would wait for her reward.

The teacher was particularly pleased with this "learning sequence." Yvette is profoundly deaf, and it is doubtful she will ever be an oral child; yet she was able, through patience, slow but definite progression, and reinforcement, to make tactual contact with the voice mechanism.

It is the teacher's belief that with time and structured learning, Yvette could learn to read lips through the vibration method.

Since the termination of this teaching experience, the teacher has introduced the "bu, bu" sound to Yvette and there is evidence that this sound will require the same slow process before it can be mastered.

The M & M reward has been to some extent "phased out" slowly and replaced by a pat on the back.

Learning Sequence

Subject: Douglas

Length of Time Observed and Taught: Two weeks

History:

Age: 3 years, 2 months

Vision: Cataract in right eye
Aphakic in left eye
Has rubella retinitis
Wears glasses

Hearing: Mild hearing loss in both ears

Speech: None

Neurologist's observations: Possible Rubella Syndrome
Slightly microcephalic
No evidence of any long standing or progressive long tract damage

Psychologist's observation: Mild Retardation to dull normal (70-80 range)

Global Objective: Simple non-verbal motor imitation

Douglas does not produce any speech sounds; so the decision was made to have his initial training consist of the imitation of a simple motor response - clap your hands.

Lesson Plan I

Teacher says: "Clap your hands" and demonstrates for child.

If child makes any approximation to the correct response, a reinforcement is to be delivered. If child does not imitate, teacher "claps" the child's hands and delivers a reinforcement.

The above lesson plan was followed for 6 days (a 20 minute session with Douglas each day) with the following results:

First Day:

Teacher said, "Clap your hands," and demonstrated. No response from

[illegible]

Peter?

Teacher said, [illegible]

child. Teacher took child's hands and clapped them and gave him an M & M. Child liked reward. This was repeated throughout the 20 minute session.

Second and Third Days:

Same as first day.

Fourth Day:

Teacher repeated procedure of days before, but helped the child clap hands from his elbow. Child responded slightly with a little effort toward clapping. Reward was continued.

Fifth and Sixth Days:

Same as fourth day except reward was withheld until child reached out and searched teacher's hands for reward.

Seventh Day:

Initial procedure was followed. After clapping child's hands from elbow twice and withholding reward until he searched for it, teacher said, "Clap your hands, Douglas" in a firm sounding voice. Child gave the correct response.

Lesson Plan II

Objective: To have child "overlearn" the command "Clap your hands."

Teacher talks to child and intersperses command "Clap your hands" throughout the session.

Eighth, Ninth, and Tenth Days:

The above lesson plan was employed for three days with the child responding correctly every time with big smile accompanying response.

Eleventh Day:

At this juncture of training, Douglas would approach the teaching station, smile, and clap his hands without waiting for the command. It was felt, at this time, that he had definitely "overlearned" the command, and the teacher proceeded to the next lesson.

white. Teacher took child's hand and [illegible]

Child liked reward. This was repeated [illegible]

Fingers and Right Hand

[illegible]

Lesson Plan III

Objective: To determine if child actually understood the command or if he was responding to an intonation of the voice.

Teacher substitutes commands such as "Sit your down," "Pat your head."

Twelfth Day:

Child did not respond to any of these commands. Teacher went back to "Clap your hands," received the correct response, and rewarded child.

Lesson Plan IV

Objective: To determine if child can discriminate sound of clapping hands from other sounds.

A recording of sounds was played. Included on recording was the sound of "clapping hands."

Thirteenth and Fourteenth Days:

Child listened to recording - the first sound was "walking," the second sound was "running," the third sound was "clapping." At the clapping sound child clapped his hands without visual clues from teacher. Recording was played several times for two days, and child responded correctly.

Auditory

Motor

Visual

elf-Help

AUDITORY STIMULATION AND DEVELOPMENT

Auditory training is the process of learning to develop the capacity of hearing so that the patient maintains communication with his environment.

The purpose of auditory training is to teach the hearing handicapped patient to make the most effective use of his hearing whether it is a minute amount of residual hearing or normal hearing.

I. Auditory stimulation and development

   A. Gross auditory stimuli.

      1. Exploring sounds

      2. Sound localization

   B. Gross auditory discrimination

    1. Attends and listens

    21 Matching sounds

C. Fine auditory stimuli

    1. Animal sounds

    2. Human sounds

3. Environmental sounds

D. Fine auditory discrimination

1. Attends and listens

2. Matching sounds

a. Intensity

b. Rhythm

c. Pitch

AUDITORY TRAINING

1. The value of hearing in the deaf child still tends to be underestimated. Yet there is considerable evidence accumulating that even small amounts of hearing are of value. The fundamental difficulty appears to be in accepting the fact that "hearing" has to be learned and that certain physiological and psychological conditions are essential for this learing process to proceed. Whetnall, Eith; "Use of Hearing by Deaf Children", Proceedings of the International Congress of Education of the Deaf, 1963, p. 271.

   1.1 Because a sound is audible it is not necessarily understood. We are concerned with auditory discrimination that involves more than sensitivity. Carhart, Raymond; "Auditory Training," Hearing and Deafness, 1960, p. 368-386.

   1.2 Hearing in man is unique; it is acquired by learning. All sounds are first noises without meaning. Whetnall, op. cit.

   1.3 While it is not visible to the observer, a normal infant's native language is unfamiliar to him until he learns it. Just as he learns how an object looks, feels, tastes, and smells, he learns how it sounds and learns the sound of the label.

   1.4 In addition to language being loud enough and meaningful enough, it also must be repeated often enough for the child to learn it.

   1.5 Auditory perception begins with intimate self-experience and gradually extends into the surrounding world. M.R. Costello, "Hearing with Impaired Ears", Proceedings of the 42nd Mtng. of the the Convention of Am. Ins. of the Deaf; 1965, p. 273-283.

2. The use of resdual hearing is not something that can be compartmentalized into specific periods on the educational time-table. To be effective, to be part of the child's total means of communication, it needs to be begun as early in life as possible and to be continued all the time, not only in school but out of it as well. Watson, T.J., The Use of Residual Hearing in the Education of Deaf Children, 1961.

   2.1 Hearing must function as an inherent part of the child's behavior if it is to be fully exploited in communication growth. This means that amplification which makes sound accessible, must be a continuing part of the child's world. Costello, op. cit.

   2.2 Hearing was not meant to be turned off like vision.

   2.3 The deaf child must hear more speech and louder speech so that he may learn the phoneme system and acquire the statistical knowledge that we all use when we take in speech. D. B. Fry; "Speech", International Congress, op. cit., p. 183-191.

3. We must not withhold the opportunity for the acoustic stimulation from any child, no matter how deaf we think he is in the first place.

   3.1 The audiogram records only one dimension of hearing and does not predict infallible, either the problems or potential of residual hearing.

3.2 It is suggested that when the hearing impaired child becomes a dominantely visual being, it is difficult to develop reliance upon either hearing alone or in combination with vision.

4. A child born with a severe hearing loss may improve in speech intelligibility, speech perception, language skills, and psychological adjustment by use of auditory training. S. R. Silverman "Clinical and Educational Procedures for the Deaf," Travis (Ed.), Handbook of Speech Pathology, 1957, p. 389-425.

4.1 Language is a temporal event but the severely-hearing impaired were not handicapped in serial learning of identifiable auditory material. F. Berg, "Serial Learning - An Approach to a Rationale for Auditory Training", Proceedings - Congress, op. cit., p. 946-54.

4.2 Language is an auditory-vocal process.

4.3 It is possible for a child with a severe congenital loss to acquire auditorially, intonation, pitch, rhythm, duration and stress which carry linguistic meaning. D. Ling, "Implications of Hearing Aid Amplification below 300 cps." Volta Review, Dec. 1964.

4.4 There are other kinds of cues for discriminating speech counds which are multiple. In fact, the cues for all phoneme distinctions could be represented by considering one of two alternatives on each of 12 dimensions:

voiced - unvoiced
short - long
compact - widespread spectrum
strong - weak
single - multiple
discontinuous - continuous
consonant - vowel
grave - acute

R.

R. Jacobson and M. Halle, Fundamentals of Language, 1956.

4.5 Experiments show that syllable discriminations are available to the deaf whose residual hearing is restricted to the low frequencies and also requires considerable amplification. Liberman, et al, "Minimal Rules for Synthesizing Speech", Jr. Acoust. Soc. Am., 1959, p.1490-99

5.

5. There is no sharp line between the hard-of-hearing and deaf children. There seems to be, rather, continua of seriousness or degree of hearing loss, of general intelligence, of linguistic intelligence or aptitude, and of motivational levels. Along with such continua there is a variety of educational techniques that includes the learning of auditory perception (perhaps subdivided as mere audibility, phonemic discrimination, discrimination of other dimensions of speech), the learning of speech behavior through response corrected by hearing or by other sensory information, the learning of the principles of language and the higher thought processes that seem to depend on such principles, and the learning of the social art of communication. I. J. Hireh, op. cit., p. 181-182.

Motor

Visual

elf-Help

MOTOR DEVELOPMENT AND PHYSICAL THERAPY TECHNIQUES

OBJECTIVES

Learn the basic principles of development.

Recognize the sequence of normal, gross, and fine motor development.

Recognize the deviations from the sequence of normal gross and fine motor development.

Understand how the knowledge or normal motor development can be used in a stimulation program for children who demonstrate delay of motor development.

Format:

Motor Development---

A. Definition

B. Principles of Development

C. Generalized Development Patterns
    Birth to 3 Months
    3-6 Months
    6-9 Months
    9-12 Months
    1-2 Years
    3-5 Years

D. Levels of Development and Treatment - Demonstration
    1. Head control
    2. Eye control
    3. Grasp-release
    4. Rolling
    5. Prone Prop
    6. Pull-up
    7. Sitting
    8. Quadrupedal position
    9. Kneeling
    10. Half-kneeling
    11. Standing
    12. Gait
    13. Fine Motor control

Developmental Chart

Compiled by: Mickey Baron, Physical Therapist
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Age	Gross Motor	Fine Motor	Social and Emotional	Preceptual Motor	Cognitive	Hand Function
1-2	Prone-Flexor Tone Supine-Extensor Tone Lifts Chin-Prone	Grasp Reflex Holds Rattle Holds hands together	Smiles Vocalizes	Sensory Imput Mother Sucking	Alert to noises	Puts hands to mouth Holds rattle-palmar reflex
3-4 mos.	Up on forearms Roll to supine Lift head in prone	Reaches for object with both hands. Shakes rattle	Discriminates strangers Vocalizes Attitudes	Symmetric Posture esp. hands Hands engage at midline Eyes Fixate Arms activate at sight of toy	Reaches, plays with objects. Looks at small objects	Approaches toys with hands - Take to mouth Pulls at clothes
5-6 mos.	Sits leaning on hands Lifts head in supine Puts toes in mouth	Picks up cube. Puts objects in mouth Transfers cubes from one hand to other. Lift cup by handle	Reaches for people Plays with people Fusses for attention	Feet in mouth (body image) Rolling (space and direction) Objects from one hand to another	Looks for things which have fallen out of sight. Actively manipulates objects.	Palmar Grasp in pronation Grasp feet in supine and plays with toes. Pick up 1 inch cube Sits propped for 30 seconds
7-9 mos.	Sits briefly at first. Stand holding on - bouncing. 9 mos.-sit for 10 minutes. Goes from sitting to prone and crawls backward usually	Hold and eat biscuits Hit blocks against each other Grasp with thumb and forefinger Holds toy in one hand and moves its part with other	Begins to imitate motor activities. Repeats things laughed at. Cooperates in games	Sits and explores environment. Hold one hand Explore object with other. Crosses midline	Actively explores all toys and the environment. Understands no.	Bilateral hand use-crosses Midline Bangs objects on table. Grasps in half supination bites Holds bottle Radial Digital Grasp

Age	Speech and Language	Vision
1-2 mos.	Cries, swallows 2 mos., Smiles, single vowels ah, oh, uh	Not well developed Follows object to midline 2 mos. Past midline
3-4 mos.	Coos-chuckles Makes vocal, social responses Sucks fingers Anticipates feeding by opening mouth	Eyes follow a moving object for short distances Color vision beginning Prefers midline head position for best all around vision
5-6 mos.	Turns head towards bell ringing	Eyes and hands come into joint action Eyes"pathfind" intently for hands
7-9 mos.	Says da-da Imitates sounds Real chewing begins Recognizes strangers Transfers food in his mouth with his tongue Responds to name and no, no	Nothing New--Developing old skills

Age	Gross Motor	Fine Motor	Social & Emotional	Perceptual, Motor	Cognitive	Hand Function
10-12 mos.	Sit-good control Standing-makes steps at rail Walks with hands held May stand alone momentarily	Places & releases objects Throws toys Hold two small objects in hand Uses index finger to poke Builds 2 blocks Marks with pencil	Jabbers Imitates words Rarely goes far from significant adults	Release objects Better use of hand & arm Finger grasp	Puts in & takes out Explores environment	Inferior pincer grasp Pokes at things with extended finger Picks up crumbs Releases objects Drinks milk from cup held for him Puts objects into container 12 mos. almost adult grasp Hits objects together Eating -messy
13-15 mos.	Walking alone or hold-arms at side 15 mos. - walks Creeps up stairs	Rolls ball to adult Put in and takes blocks out of box Scribbles place circle in formboard	Increase control over people thru gestures Clear demonstration of emotions	Walking More of a fine grasp Release of small objects begins	Begins to Discriminate forms Recognizes name of things	Scribbles Build tower of 2-3 cubes
18 mos.	Walks, seldon falls Arms at side Runs stiffly Up stairs Has all decidous teeth by 18-21 mos.	Puts square in formboard Places loose fitting lid on box Tower 3-4 cubes Fills and dumps containers	Names 1 or 2 things Strong need to please Uses temper tantrum to get what wants	Seat self in chair Hurls ball Pulls toy Runs stiffly Go down stairs	Build with blocks Discriminate borms Follows relatively simple directions	Hurls ball Puts pellets in bottle Carries and hugs doll Makes vertical scribbles Builds 3 cubes
21-24 mos.	Squats in play Kicks ball Up & down stairs Runs fairly well Ankles & knee more flexible	Uses one hand more than other Puts circle, square triangle in formboard Tower 5-6 Turn pages ingly Unscrews lids	Strong attachment to people, objects Willful, not easily distracted from a forbidden activity Parallel play	Walks, runs & squats Kicks ball Tower 6-7 Holds doll to feed Jumps off step	Follows instructions well Language expanding	Builds 5-6 and 6-7 cubes Handles cup well Puts on socks Pulls up pants Imitates a circle supination

Age	Speech and Language	Vision
10-12 mos.	Plays patty-cake, waves bye-bye Mama, da-da, plus one word Babbles and smiles in mirror Reacts to music, 12 mos., 2 words Gives toy on request	Nothing New
13-15 mos.	Imitates adult speech Copying the melody and dynamics of speech 3-4 word vocabularly, then 4-5 Turns pages and pats pictures in book Indicates wet pants	
18 mos.	Mastering symbols Names ball 10 word vocabularly Indicates wants by pointing Understands simple sentences	
21-24 mos.	Has 20 words Simple expressions I, me, you 3 word sentences Understand 50 words Verbalizes toilet needs	Vision 20/70

Age	Gross Motor	Fine Motor	Social & Emotional	Perceptual Motor	Cognitive	Hand Function
3 yrs.	Walk on tiptoes Jumps with both feet	Imitates vertical, horizontal & circular Tower of 8 Strings 4 beads	Trusting threes Beginning of cooperation Play with peers Can be bargained with	Stand momentarily on one foot Walk on tiptoes Pedal tricycle Walk upstairs alternately using feet Unbutton clothes Feeds self well Copies at 3½ yrs.	Expanding language Learning mostly by association & imitation	Crayons in fingers rather than fist 9-10 cubes Copies circle Feeds self well Put on shoes
4 yrs.	Broad Jump	Hand control constantly improving	Frustrating fours Talks to maintain contact with people Sure he knows everything Fabrication & bragging	Hop 10 or more steps with both feet Hop 6 steps on one foot Throw ball 8-9 feet Both hands used well & complexly Copies cross & square	Talks like an adult Learning by intuition	Throws ball overhand Copies square & cross Draw man with two parts Washes face, hands, teeth laces shoes
5 yrs.	Jumps rope Walk a line Roller skates Skips alternating feet		More dependence on peers Can play constructively by self for long periods Takes pride in helping	Hops on one foot 10 or more times Down stairs alternating feet Cut with scissors Reciprocally release and string beads	Learning still by intuition Beginning to experiment more	Draws a good man Copies triangle Prints a few letters Dresses & undresses alone
6 yrs.	Stand on one foot alternately, eyes closed After 6 all basic motor skills acquired Maturation		Moody, wants to whine - trying time for child and parent Wants acceptance by peers	Ties shoes Copies diamond More complex tasks	Confused by perceptions d vs b	Advanced throwing pattern Copies diamond Draw a man with clothes Ties shoelaces Hand preference

Age	Speech and Language	Vision
3 yrs.	Names his drawings Tells his sex, uses plurals Well formed simple sentences Ask rhetorical questions Dramatic play Understand taking turns	
4 yrs.	Counts 3 objects pointing correctly Names one or more colors Know front from back	
5 yrs.	Counts to ten Knows 4 colors Ask meaning of words	Vision 20/30
6 yrs.	Knows morning from afternoon Left from right	Vision 20/20 by age 7

ORIENTATION AND MOBILITY TERMS

1. Orientation: The process of utilizing the remaining sneses in establishing one's position and relationship to all other significant objects in one's environment.

2. Mobility: The term used to denote the ability to navigate from one's present fixed position to one's desired position in another part of the environment.

3. Clue: Any sound, odor, temperature, tactile stimulus affecting the senses and can be readily converted in determining one's position or a line of direction.

4. Dominant Clue: Of the maze of clues that are present, the one that most adequately fulfills all of the informational needs at that moment.

5. Landmark: Any familiar object, sound, odor, temperature, or tactile clue, having a known and exact location in the emviornment, which is readily and consistently recognized.

6. Information Point: A familiar object, sound, odor, temperature, or tactile clue, whose exact location in the emviornment is known but is less apt to be recognized or perceived than a landmark, e.g., water fountain; narrow sidewalk grating.

7. Sound Localization: To dertemine the exact bearing or line of direction of the source of a sound.

8. Run: The term used to denote a course or route mapped out and traveled to a given point or objective--as a "run down to the bakery", or "The Twentieth Century has the run between Chicago and New York."

9. Shore Line: The border or edge of a sidewalk or grassline.

10. Sighted Guide Technique: A blind person lightly grasping a sighted guide's elbow in taking a walk.

11. Trailing: The act of using the back of the fingers to follow lightly over a straight surface (e.g., wall, lockers, desks, tables, ect.) for one of the following reasons:
    a. to determine one's place in space
    b. to locate specific objectives
    c. to get a parallel line of travel

12. Direction Indicator:Refers to any straight lined objects whose surface lines when progected into space will give you a course or line of travel in a given direction or to an objective.

13. Direction Taking: The act of getting a line of course from an object or sound to better facilitate traveling in a straight line toward an objective. (Dynamic situation).

14. Squaring Off: The act of symmetrically aligning and positioning one's body in relation to an object, for the purpose of getting a definite line of direction and establishing a definite position in the enviornment. (Static and Definite).

15. Sound Shadow: A region of relative silence behind an object which filters out the sound waves.

16. Echo Location: Auditory perception of objects or space by emitting a sound and perceiving the direction and quality of the reflected signals.

17. Mobility terms to be used and understood are: North, South, East, West, Right, Left, Right Angle, Parallel, Veering to one side, Square Corners.

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I. USE OF THE SIGHTED GUIDE

OBJECTIVES

1. Functions as a safe and efficient technique.
2. Promotes active participation and independency.
3. Is socially acceptable.
4. Allows the client to compensate for a poor guide.
5. Allows the client to function through interpretation of the guide's movements.

A. BASIC TECHNIQUE

1. PROCEDURE:

   a. Making contact with the client.

      1) The experienced sighted guide makes contact by touching his elbow to the opposite elbow of the client.

      2) The inexperienced sighted guide:

         a) The client locates the center of the guide's back and moves his hand laterally across to the elbow.

         b) The client moves the forearm nearest the guide horizontally until contact is made.

   b. The guide's arm is grasped above the elbow with the client's fingers on the medial side of the humerus and the thumb on the lateral side.

   c. The client flexes his elbow to approximately a 90° angle and keeps the upper arm close to his body.

   d. The client follows one-half step behind the guide with his shoulder directly behind the opposite shoulder of the guide.

2. OBSERVATIONS:

   a. This technique may be modified to a child's height by having the child grasp the quide's wrist.

   b. If the guide needs to leave the client, he should find some concrete object (tree, bench, wall, ect. so the client will not feel as if he is standing in space.

   c. The client should keep his upper arm close to his body to avoid moving beyond the protection of the sighted guide.

B. NARROW SPACES

1. PROCEDURE:

   a. The sighted guide hyperextends and adducts his upper arm.

   b. The client fully extends his elbow, flexes at the shoulder and moves to a position one full step directly behind the guide.

   c. After passing through the space, the guide returns his arm to the basic position, and the client does also.

2. OBSERVATIONS:

   a. The client may wish to use this method for greater protection when he is uncertain of the sighted guide or his movements.

   b. The client will want to stay one full step behind the guide so that he may position himself directly behind the guide and to avoid stepping on the guide's heels.

C. CLOSED DOORS

1. PROCEDURE: If the door is on the same side as the client.
    a. The guide's body rotates, and initially he informs the client which way the door opens.
    b. Movements for both the sighted guide and client will be less exaggerated but the same for narrow spaces.
    c. The client will use a modified hand and forearm position, starting at the midline and moving toward the door until contact is made.
    d. The client makes contact with the palm toward the door at approximately chest level.
    e. The client will support the door until clear and releases or closes the door as necessary.
2. PROCEDURE: If the door is on the opposite side of the client.
    a. The initial steps are the same as above.
    b. The client places his right hand on the guide's elbow along with the left to maintain continuous contact and then releases the left.
    c. The client is then behind and in line with the guide's body and contacts the door in the same manner as before.
3. OBSERVATIONS:
    a. The client should be informed that firedoors will lead from corridors to the outside of the building, opening outward.

D. DESCENDING STAIRS

1. PROCEDURE:

   a. The guide approaches perpendicular to the top step and stops.

   b. The client, keeping his body weight balanced over the heels, takes half-steps forward to find the top step and continues down the stairs one step behind the guide.

   c. The client will be able to determine the bottom of the stairs when the guide's arm returns to position beside the client.

2. OBSERVATIONS:

   a. The guide will be able to break possible falls if he keeps the client between himself and the railing, but the railing should not be used by the client.

   b. Special clients may need to use the railing.

   c. A pause at the top step may replace the complete stop as the client becomes more proficient.

   d. When using spiral stairs, the client should take that part of the step which has the most regular tread.

E. ASCENDING STAIRS

1. PROCEDURE:

   a. The guide approaches perpendicular to the bottom step and stops.

   b. The client, keeping his body weight slightly forward, takes half-steps forward to find the step and continues up the stairs one step behind the guide.

c. The guide will take one step forward at the top step and stop to avoid the client taking a false step.

d. The client will be able to determine the landing when the guide's arm is the level used in the basic technique.

2. OBSERVATIONS:

a. The client may want to search for the front of each riser with his foot, but he should be discouraged from doing so.

F. APPROACH TO AND SEATING IN A CHAIR

1. PROCEDURE:

a. Approaching the back of a chair.

1) The guide leads the client to a perpendicular position one-half-step from the back of the chair and indicates the position and proximity.

2) The client uses the lower hand and forearm to locate the back of the chair with the dorsal surface of the hand.

3) The client maintains contact with the chair while he moves to the front.

4) The client checks the back and seat of the chair to make sure it is clear of any objects.

5) The client aligns the calves of his legs with the front edge of the chair and grasps the arms or sides of the chair as he is seated.

b. Approaching the front of a chair.

1) The guide brings the client to the front of the chair in the same manner as the back.

        2) The client extends his leg to make contact with the anterior portion of the lower leg to the front of the chair.
        3. The client clears the chair, aligns and is seated in the same manner as above.

2. OBSERVATIONS:
    a. Contacting the chair will give the client more information more quickly than the sighted guide can verbalize.
    b. Purposes for clearing the chair before seating.
        1) The client may clear the chair of objects.
        2) The client may determine the type of chair.
    c. The client should square off with the chair before being seated.
        1) The client may make sure he is centered on the chair seat.
        2) The client may judge the height of the chair.
    d. The client should sit back in the chair slowly in case there are any objects behind his head.
    e. If the client is entering a room alone, he should inquire as to where there are available seats.
    f. This technique will need re-inforcement during lessons at various times for retension.

G. SEATING AT A TABLE

1. PROCEDURE:
    a. The guide leads the client to the back of his chair in the same manner as approaching the back of a chair.

b. The client uses the dorsal surface of his hand to follow laterally the back of the chair until he makes contact with the edge of the table.

c. The client maintains contact with the table throughout the procedure and pulls the chair out to a position where he may seat himself.

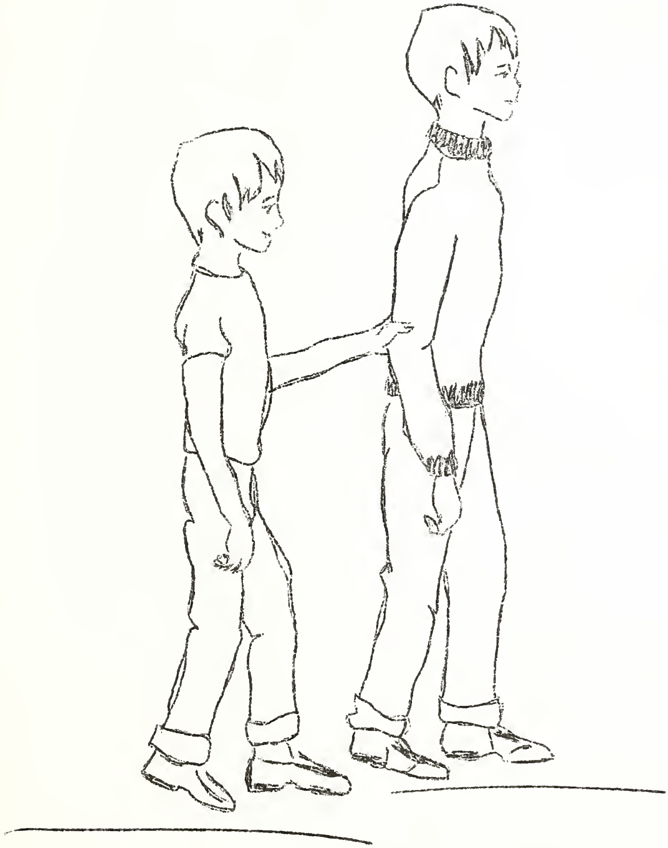
d. The client clears the chair, aligns, is deated and pulls the chair up to a comfortable position at the table.

e. The client squares off with the dorsal surface of bothhands along the table's edge.

2. OBSERVATIONS:

   a. If the client uses the dorsal surface of the hand or the fingertips to maintain contact with the table, he will avoid upsetting dishes and utensils.

SIGHTED GUIDE

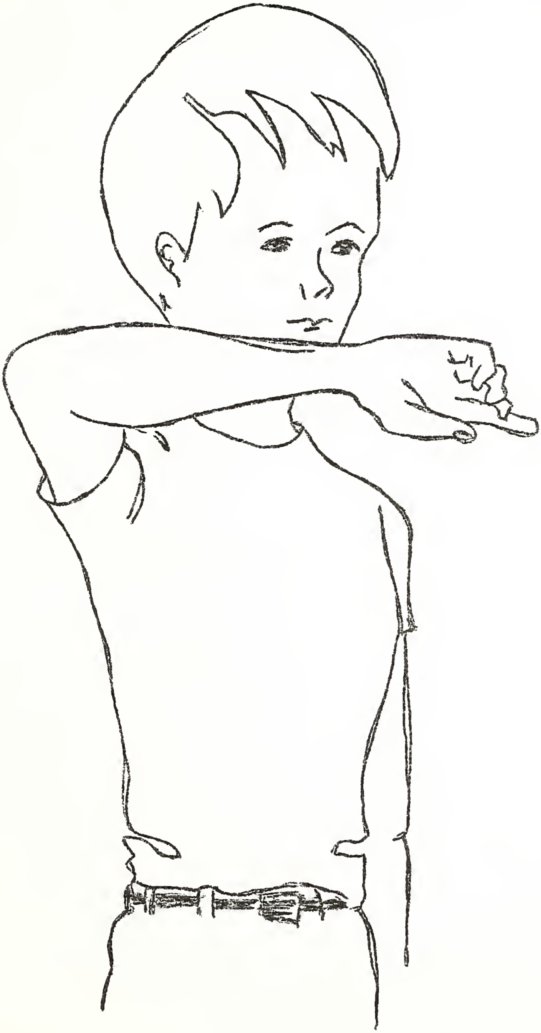


III. HAND AND FOREARM TECHNIQUES

A. THE UPPER HAND AND FOREARM

1. OBJECTIVES:
    - a. To protect the client's upper body from injury in a controlled enviornment.
    - b. To aid in eliminating blindisms.
2. PROCEDURE:
    - a. The client flexes the arm at the shoulder and flexes the elbow to form an obtuse angle with the upper arm.
    - b. The client inwardly rotates the forearm until the palm is anterior with the fingers extended.
    - c. The client's fingertips will be aligned with the lateral plane of the opposite shoulder.
3. OBSERVATIONS:
    - a. The reason for the obtuse angle.
        - 1) The fingertips will contact the object first and give greater forewarning of objects.
        - 2) The elbow will not be open for injury.
    - b. This technique may be objectionable to many clients.
    - c. This technique can be used with the cane in situations where there may be high or protruding objects.
    - d. This technique should not be used with the lower hand and forearm.

UPPER HAND AND FOREARM



B. THE LOWER HAND AND FOREARM

1. OBJECTIVES:

   a. Protects the pelvic area of the body.

   b. Is used to locate objects at that certain height.

   c. Is used in a familiar enviornment.

2. PROCEDURE:

   a. The client flexes the arm at the shoulder and adducts the arm to the cardinal-sagittal plane.

   b. The client's palm will be toward his body at approximately crotch level with the fingers extended but relaxed.

3. OBSERVATIONS:

   a. Tall people may pass over low objects unless the hand is held close to the body.

IV. THE TRAILING TECHNIQUE

A. OBJECTIVES:

1. The client will be able to locate specific objectives along walls.

2. This technique gives the client a means of parallel travel.

3. This technique gives the client a specific location in the environment.

B. PROCEDURE:

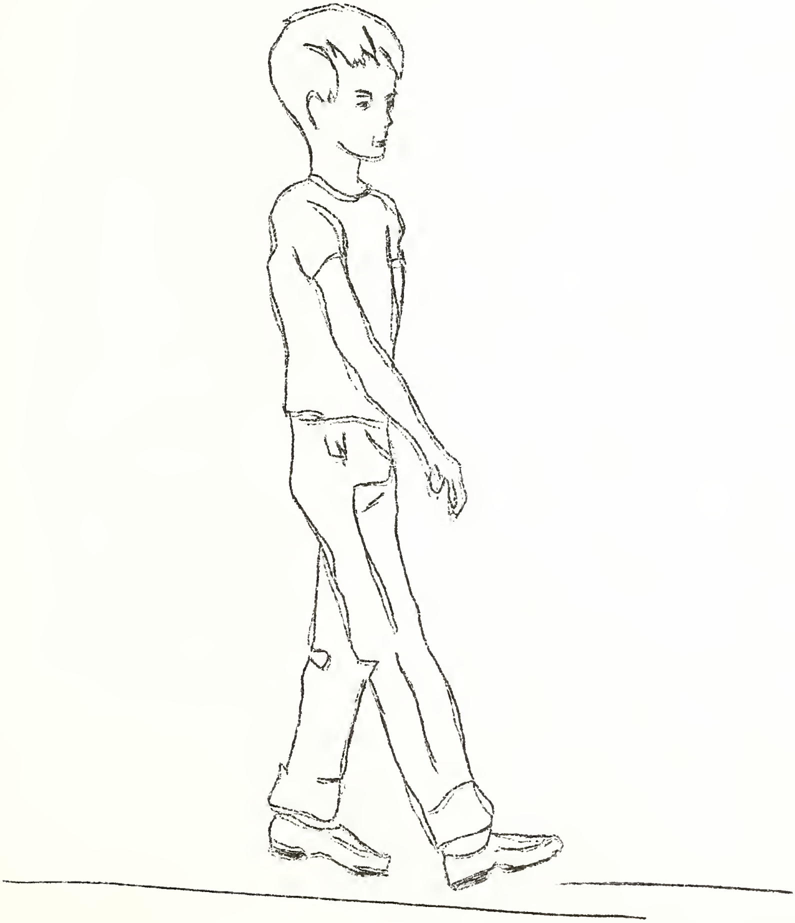
1. The client stands parallel to the wall with his shoulder approximately four inches from the wall.

2. The trailing arm is flexed at the shoulder and extended at the elbow to waist level.
3. The client inwardly rotates his arm until his hand is pronated and abducts his arm to contact the wall.
4. The client flexes his fingers to avoid injury.
5. The client's ring and little finger contact the wall and trail.

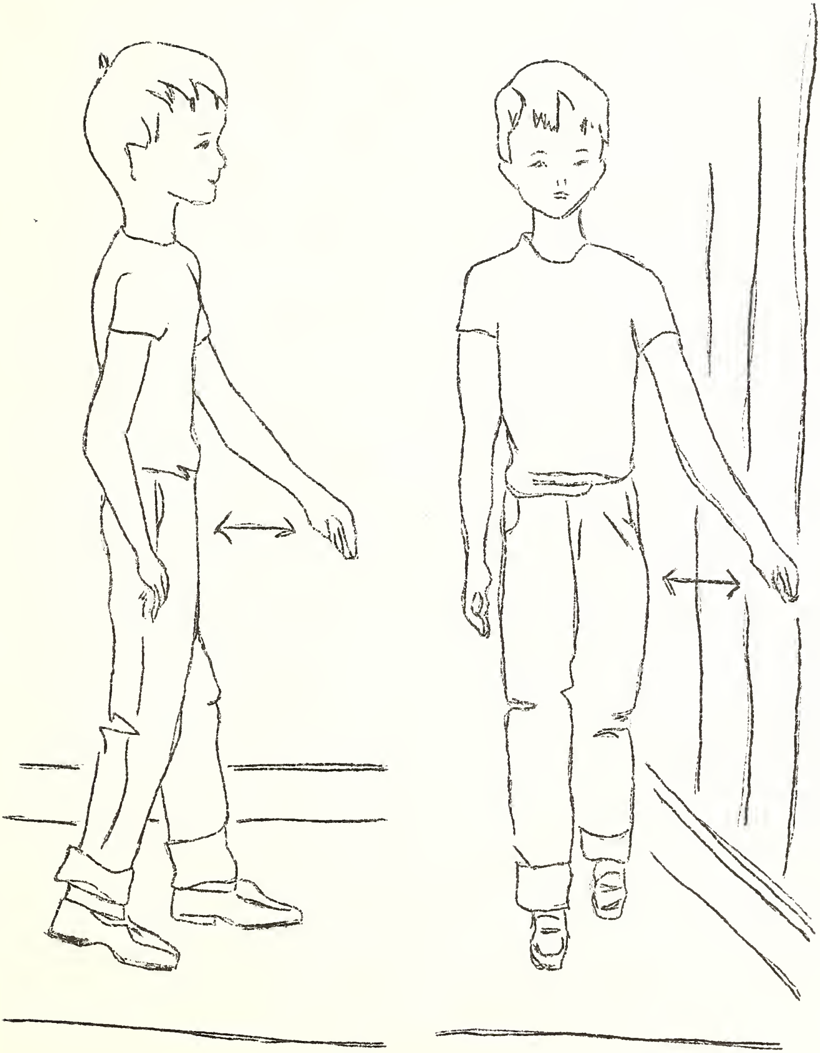
C. OBSERVATIONS:

1. This is not a protective technique so the upper hand and forearm should be used in combination with it.
2. When trailing an uncomfortable surface, the technique should be modified by inwardly rotating the forearm until the palm faces the wall and flexing the fingers until the nails contact the surface being trailed.

LOWER HAND AND FOREARM



TRAILING



Visual

elf-Help

VISION

A. Appearance of Eyes: ____________________
B First Impression: ____________________

B. Ability to Open Eyes: Right: ________ Left: ______ Both: ________

C. Quality:
Right: Cloudy ________ Clear ________
Bright ________ Dull ________
Left: Cloudy ________ Clear ________
Bright ________ Dull ________

D. Response to Light:
Pupillary: Right: ________ Left: ________
Fixation: Right: ________ Left: ________

D. Motor Control of Eyes:

Fixation Stability: Right: ________ Left: ________
Coordination: ____________
Tracking Ability:
Light: Right: ________ Left: ________
Object: Right: ________ Left: ________

F. Focal Ability: ________________________

G. Eye Contact: ________________________ How Long: ________________

H. Initative Eye Movement Ability: ______________________________

I. Ability to wink:
Right: ___________ Left: __________ Both: _______________

J. Eye Behavior When Not Attending: _____________________

K. General Descripton of Visual Behavior:

To what child visually attends: __________________
Distance of most attention: Near: ________ Inter ______ Far ______
One side preference: Yes: _______ No: __________
Which side: Right: ____ Left: ____
Eye-hand coordination: Yes ________ No: __________ Sometimes: ___
Eye direction for any actions: Yes: ____ No: _____ Sometimes _____

L. Summary of Overall Observations: ______________________________

____
____

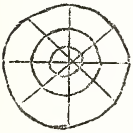
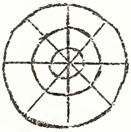
____

TEACHER'S GUIDE FOR EVALUATING VISUAL FUNCTIONING

Student Name ______________________ Sex ____ Age ____ Grade ____________

PART I

Sensation

1. Is there a reaction to light by the child?	Findings	Date	Date
	Yes		
	No		
	Comments:		
2. If there is a reaction, is it different to colored light?	Yes		
	No		
	Comments:		
3. Are there blank spots in the vision field? If so, mark the blank areas of the visual field in the diagrams below.	Findings	Date	Date
	Yes		
	No		
Left Eye  Right Eye 	Comments:		
4. Are there any abnormal reactions to light evident (light gazing, object flicking, etc.)?	Yes		
	No		
	Comments:		
5. What is the child's visual acuity, both near and far?	Acuity-Near		
	Acuity-Far		
	Comments:		

PART II - Visual-Motor

Next Page

PART II - Visual-Motor

	Findings	Date	Date
1. Is the child able to track (visually follow) a light or object?	Left-right		
	Yes		
	No		
	Comments:		
	Up-down		
	Yes		
	No		
	Comments:		
	Diagonal		
	Yes		
	No		
	Comments:		
	Circle		
	Yes		
	No		
	Comments:		
2. Is the child able to follow a light or object moving toward him?	Yes		
	No		
	Comments:		
3. If the child is able to follow a light or object moving toward him, how close is the object when he stops following it?	Inches		
	N/A		
	Comments:		
4. Can the child focus on an object near him?	Yes		
	No		
	Comments:		
5. How far away does the child hold an object when examining it? At what angle relative to his eyes. (Indicate under "comment").	Inches		
	N/A		
	Comments:		
6. Is the child able to change his focus from far to near objects?	Yes		
	No		
	Comments:		

PART II - Visual-Motor (continued)

	Findings	Date	Date
7. Does the child have eye contact with you?	Yes		
	No		
	Comments:		
8. Does the child have eye contact with objects?	Yes		
	No		
	Comments:		
9. Can the child follow objects across his midline?	Yes		
	No		
	Comments:		
10. Does the child reach quickly and accurately for objects?	Yes		
	No		
	Comments:		
11. Does the child require tactile clues in mobility and eating?	Yes		
	No		
	Comments:		
12. Can the child accurately put objects in a container?	Yes		
	No		
	Comments:		
13. Can the child climb up and down stairs accurately?	Yes		
	No		
	Comments:		
14. Can the child catch a ball?	Yes		
	No		
	Comments:		
15. Can the child kick a ball?	Yes		
	No		
	Comments:		
16. Can the child point to the parts of his body?	Yes		
	No		
	Comments:		

PART II - Visual-Motor (continued)

	Findings	Date	Date
17. Can the child finger paint, scribble, draw recognizable pictures, and/or color within lines? (Indicate which.)	Yes		
	No		
	Comments:		
18. Can the child cut along a straight line with scissors, knife, etc.?	Yes		
	No		
	Comments:		

PART III

Visual Perception

1. Does the child use common items such as cups, spoons, chairs, etc., purposely?	Yes		
	No		
	Comments:		
2. Can the child perform with a form board accurately?	Yes		
	No		
	Comments:		
3. Can the child match colors?	Yes		
	No		
	Comments:		
4. Does the child demonstrate visual memory?	Yes		
	No		
	Comments:		
5. Has the child overcome figure-ground confusion?	Yes		
	No		
	Comments:		
6. Does the child demonstrate visual sequencing?	Yes		
	No		
	Partial		
7. Can the child follow "Simon Says" directions or imitate body movements?	Yes		
	No		
	Comments:		

Continued on next page

PART III - Visual Perception (continued)

	Findings	Date	Date
8. Can the child duplicate geometric designs drawn by the teacher: straight lines, circles, squares, triangles, diamonds, etc.? Indicate which, if any.	Comments:		
9. Can the child match letters?	Yes		
	No		
	Comments:		

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Self-Help

ARLINGTON DEVELOPMENTAL CENTER

SPEECH PATHOLOGY AND HEARING DEPARTMENT

COMMUNICATION ACTIVITIES

ORAL STIMULATION

I. GOAL: To facilitate adequate lip closure and thereby eliminate drooling.

ACTIVITIES:

1) Use jaw control (Diagram 1-A) with cup and spoon feeding.
2) During feeding, press down firmly on tongue (midway) with bowl of spoon. Use jaw control.
3) Drinking from a cup. Use a cut-out paper cup (Diagram 1-B). Place lip of cup on lower lip (not inside mouth). Tip cup slightly just to let liquid touch gum - let the child do the rest.
4) Smear peanut butter or jam on both lips to encourage rubbing lips together.
5) Put lipstick on lips. Place a piece of paper or tissue between lips and see how dark an imprint the child can make.
6) Place a strip of paper or tongue blade between the child's lips (not between teeth). See how long he can hold it. Count off seconds. Praise.
7) Place a small bit of saltine cracker between lower lip and lower gum. Encourage child to work it out with his lip.
8) Place a small bit of saltine cracker between upper lip and upper gum. Encourage child to work it out by pulling lip down.
9) Tie a piece of string to a medium sized button. Place the button between the child's teeth and lips. Gently pull the button by the string. See if the child can hold the button with his lips. Play tug of war with the button on each end of the string.
10) Use verbal cues. "Close your lips."

MATERIALS:
Tongue blades, peanut butter, cut-out paper cups, spoons, dark lipstick, tissue, paper, strings, buttons, crackers.

II. GOAL: To facilitate chewing.

1) Use jaw control (Diagram 1-A).
2) Place bit of graham or saltine cracker on side of mouth between teeth with fingers to get good voluntary bite. Use jaw control.
3) Use strips or fingers of dark bread placed between teeth (molars) on side of mouth. Pull gently to give the child the feeling of strength of bite.
4) Push a raisin firmly onto a molar on one side - alternate sides. Use jaw control.

MATERIALS: Graham crackers, saltines, dark bread, French bread crust, raisins.

EATING TECHNIQUES FOR THE DEAF-BLIND

I. Location of Plate, Utensils and Glass

A. Utensils, plate and glass should always be in same place. Glass should be placed directly in front of arm in rest position.

B. Allow resident to feel where utensils, plate and glass are placed. Feel outline of tray if there is food on the tray. If no food is present, let the resident feel all of the tray or plate. Let him feel location of spoon and napkin.

II. Resident picks up napkin with two hands and places it in lap.

III. Pour milk in glass

A. Milk should be placed to the left of glass.

B. Resident places index finger of right hand in glass. Finger will tell him when the glass is full.

C. Resident picks up carton with spout in correct direction and pours milk.

IV. Location of food

A. Always place each type of foods in the same location.

With physical guidance, the child will pick up spoon and touch each item on tray or plate. Instructor will name foods as he touches them.

V. Use of Pusher

A. Use the same spoon feeding techniques as in the past.

B. Place spoon in resident's preferred hand and folded bread in other.

C. Place bread to the side of his first bite.

D. Scoop food with spoon, pushing against bread.

E. Return spoon to mouth.

VI. Cutting with Knife

A. Spear meat with fork, using left hand

B. Place left index finger on back of fork and grip handle with other fingers.

C. Place left index finger on back of knife and grip handle with other fingers.

D. Place knife against back of fork.

E. Cut

F. With fork in meat, raise knife and place in front of fork.

G. Remove fork and place behind knife.

H. Cut

I. Repeat steps.

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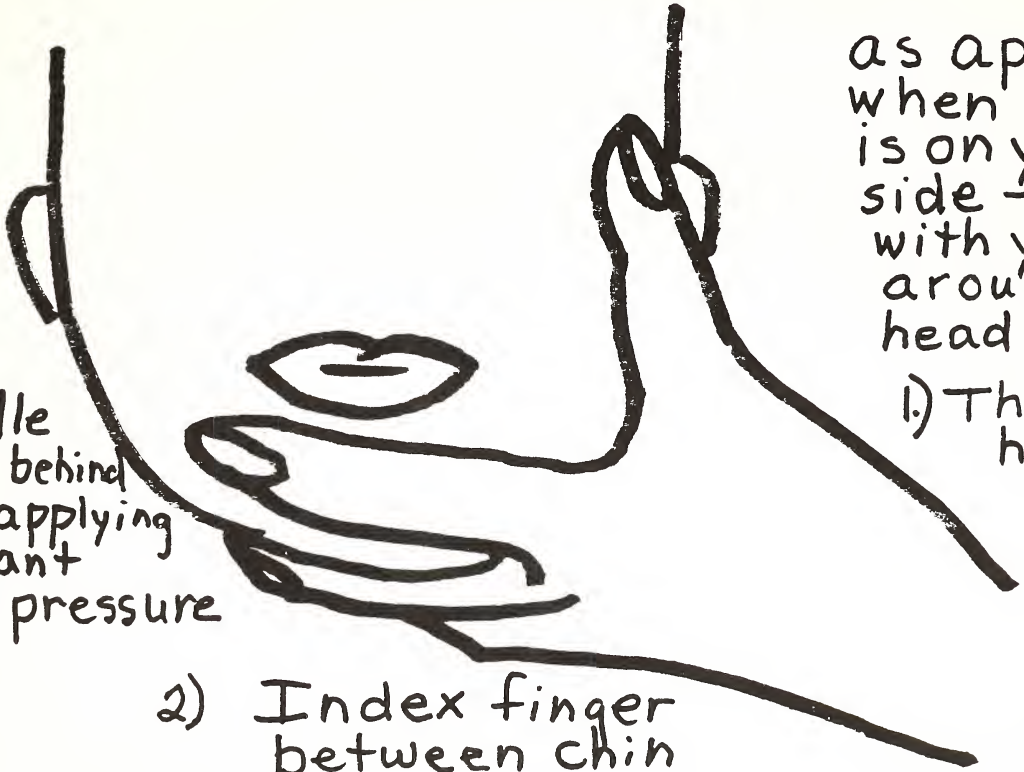
Jaw Control...



as applied when the child is on your left side - or lap - with your arm around his head

1.) Thumb on his jaw joint

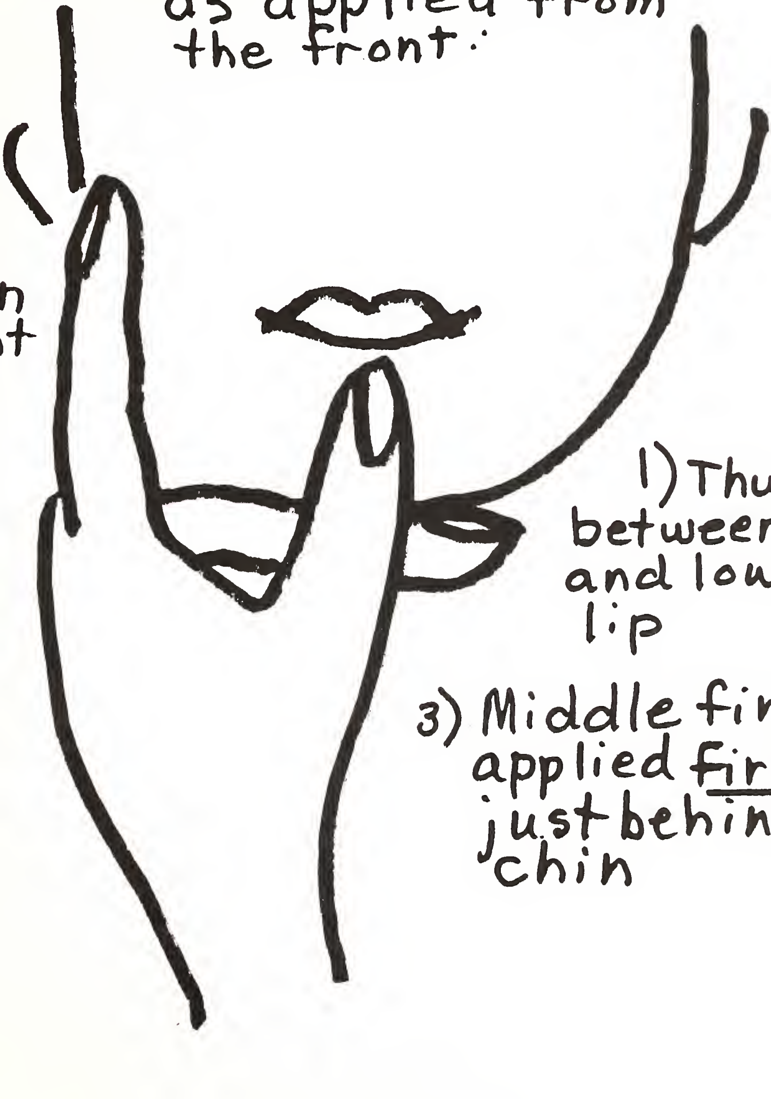
2) Index finger between chin and lower lip

3. Middle finger behind chin applying constant FIRM pressure

1-A

Jaw Control..

as applied from
the front:



)Index
inger on
aw joint

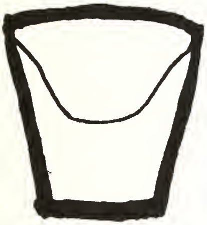
1) Thumb
between chi
and lower
lip

3) Middle finger
applied firmly
just behind
chin

1-A

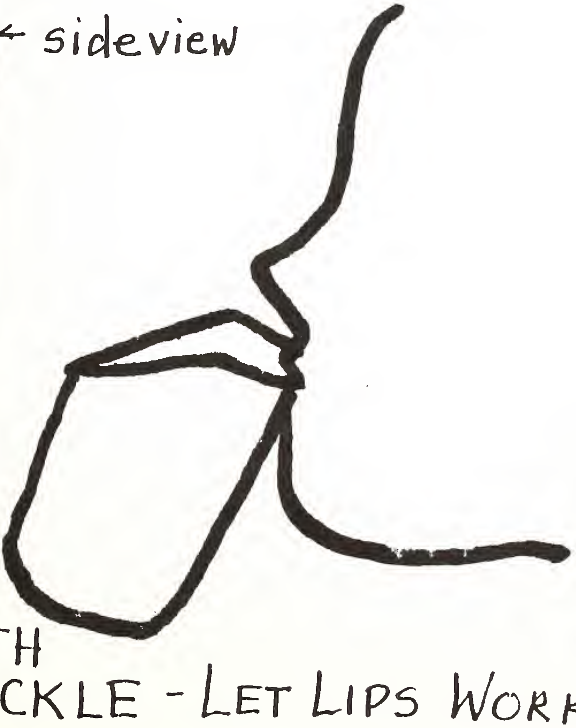
1-B

CUT-OUT CUP



← CUT OUT U shaped slot for nose and easy viewing of amount of fluid given

← sideview



U slot faces helper, not child. →

START WITH JUST A TRICKLE - LET LIPS WORK!

The attached chapter is from a forthcoming book entitled A Comprehensive Handbook for Management of Children with Developmental Disabilities, Sue White and Jane Wilson Minor, editors.

This book is now in press by the University of Tennessee Medical Units and should be available by June, 1977. For further information, contact Ms. Hazel Capps, University of Tennessee Child Development Center, 711 Jefferson, Memphis, Tennessee 38105.

Chapter 12

BEHAVIORAL ASPECTS OF SELF HELP SKILL DEVELOPMENT

Jane Wilson Minor

I. General Considerations

Before any self help skill is taught, there are several aspects of the child's behavior which must be taken into consideration. As discussed in the previous chapters, a developmental assessment should be made to determine if the child is physically capable of acquiring the skill. After this assessment has been made and it is determined that he is physically capable to learn a skill, then assessments should be made in the following areas:

A. Mental Age (as determined by psychological testing).

Mental age is useful in determining if a child is ready to learn a skill. Obviously, if a child is 6 years old and is functioning at a 6 month old level, he probably is not ready for any kind of self-help skill development.

Mental age alone should never determine a child's readiness.

B. Behavior Problems

Any inappropriate behavior (aggressiveness, hyperactivity, self stimulation, temper tantrums, and distractibility) which occurs at a high frequency will interfere with the acquisition of a self help skill. These behaviors are incompatible with learning because the child cannot focus his attention on the skill to be learned while emitting the inappropriate behavior. For this reason, the inappropriate behavior should be managed before a self help skill development program is attempted.

C. Appropriate Skill

Usually there is no question about what skill is to be taught first. However, in some instances, a parent might insist on toilet training or speech development before the child can feed himself. A general rule to follow is that self help skills should be taught to retarded individuals in the same developmental sequence as they are to normal children: feeding skills - dressing - toilet training, etc. There will be exceptions to this rule, but probably not many.

It is possible to teach more than one skill at a time, but there are some dangers in doing this. Each self help skill is a set of complex behaviors for the child to learn. Learning

more than one set of these behaviors at a time may be confusing and difficult. Because of this, the child is usually unable to devote sufficient attention to either one to acquire that skill.

D. Readiness

Once the skill to be taught has been determined, then it must be decided if the child is ready. All of the areas which have just been covered should be taken into consideration. In addition to this, the child should be observed for readiness cues. These cues will be discussed under each self help skill. An example would be a child pointing out a wet diaper to his mother.

E. Reinforcers

Effective reinforcers are a necessity in teaching any self help skills. Before the training program is begun, several effective reinforcers should be identified. The only exception might be feeding skills, which has a built-in reinforcer (meals). Even so, social reinforcement will be necessary.

F. Attending Behavior (Eye Contact)

The ability to attend to a task or make eye contact on command is a requirement before any kind of new behavioral development is begun. If the child does not attend, it will be difficult or impossible to teach him a new skill. This does not mean that he must be able to focus on the task constantly. It does mean that he will be able to attend to the task long enough to see what is expected of him.

Some programs, such as intensive feeding skill programs, have techniques written into them to develop or maintain attending behavior. If the program to be used does not have this feature, then the following technique might be used to develop attending:

1. Call the child's name while holding the reinforcer in front of your face. ("John, look at me.")
2. If he makes eye contact, reinforce him immediately. If not, you may need to turn his face toward yours and reinforce him.
3. When he attends each time you give the command, begin moving the reinforcer away from your face, until he is attending to you with no reinforcer in sight and without any prompting.
4. When the child will attend (look at you) approximately 90% of the time asked with infrequent reinforcement, then the program can be terminated.

This is only one suggested technique for developing eye contact. There are other methods and the best one for the child should be utilized.

G. Response to Commands

To facilitate learning of any skill it is a necessity that the child not be oppositional and be able to respond approximately to simple commands. Inappropriate behaviors such as tantrums or negative responses to commands must be extinguished. The following are some suggested techniques for developing cooperative behavior:

1. Shape appropriate command responses by giving the child simple directions and reinforcing all positive responses.
2. If he does not understand the command, demonstrate it for him. Then, if he does not respond, manually guide him through the appropriate response.
3. Tantrums should always be ignored.
4. If any type of management procedure is necessary, such as chair time out for tantrums, when the time out is over, return the child to whatever he was doing before the time out was necessary.

H. Prompting

In order to minimize training difficulties and assist the child in learning the skill it may be necessary to make use of two other behavioral techniques. These are prompting and shaping. This is simply providing the child with some assistance in learning what response is expected of him. There are three categories of prompts which can be used separately or together.

1. Verbal - Telling the child what to do, slowly, simply, and clearly. For example, "John, take off your shirt." Verbal prompts can also be just one word.
2. Gestural - Going through the motions necessary for the desired response. For example, pointing to a chair for the child to go to it.
3. Physical - Guiding the child through the response. Do not use force, but give the child physical assistance.

Prompts should be faded out (reduced gradually) as soon as possible, so that the child does not learn to depend on constant assistance.

I. Shaping

In teaching any self-help skill it is better to break the skill down into small steps rather than teach the entire skill at once. This is done because self help skills are complex behaviors to learn.

By breaking them into smaller steps or behaviors, it gives the child an opportunity to succeed at achieving a goal, rather than being frustrated because he is not able to complete the entire skill. This process of teaching a skill by using small steps is called shaping.

In shaping, one behavior leads to another until the total skill is achieved. The first response to be taught is the one that completes that total behavior and is the closest to the reinforcer. Once that response is learned, then the next to the last response is taught and so on. This is called chaining, because a chain of responses is built which leads to the total behavior.

For example, in teaching a child to put a shirt on you would begin by teaching him to pull his shirt down, then to pull it over his head, then to put one arm in, and so on until he could put his shirt on with no assistance.

II. General Feeding Procedures

A. Feeding Skills

Self-feeding is a very important behavior for the child to acquire, because it is usually the first self-help skill acquired and the activity has a built-in reinforcer, the food. Since feeding is the child's first accomplishment in self help, it allows the first independent behavior of the child in caring for his bodily needs. Also, since the food is reinforcing, care must be taken to insure that inappropriate feeding behaviors are not learned. As in any other behavior shaping program, one of the first steps is to break the behavior into small steps. An example of the components for the chain of "eating with a spoon" is:

1. Orients to food by looking at it
2. Looks at spoon
3. Reaches for spoon
4. Touches spoon
5. Grasps spoon
6. Lifts spoon
7. Delivers spoon to bowl
8. Lowers spoon into food
9. Scoops food into spoon
10. Lifts spoon
11. Delivers spoon to mouth
12. Opens mouth
13. Inserts spoon into mouth
14. Moves tongue and mouth to receive food
15. Closes lips
16. Chews food
17. Swallows food
18. Returns spoon to bowl

The most effective way to teach these behaviors involves a combination of manual guidance and reinforcement (which involves physical assistance). A baseline should always be done first to assess the child's present abilities in that area. Cheerful praise and physical contact should be used frequently for each correct response. The praise should be used to reinforce closer approximations to the desired response. Motivation for correct responses should be provided by brief time-outs for incorrect responses. Whatever program is established for a given child, it cannot be overemphasized that the procedures should be consistent and that the consistency must be applied to each meal. Otherwise, the child will be confused and progress will be slow.

There are some important points to remember in any feeding skill development program.

1. Once the training program has begun, the child should receive no unsupervised meals. This is inconsistent and will make training more difficult.
2. Begin with a simple response and move to a more complex one. You would not expect a child to be able to cut his meat before he can use his spoon.
3. Make the meal a positive event by using continuous reinforcement during training for all correct responses.
4. Do not allow any inappropriate behavior to continue during mealtime. These incorrect behaviors would be strengthened because food is a reinforcer.

The method used during the meals involves:

1. Graduated manual guidance
2. Reinforcement of correct responses
3. Overcorrection of errors
4. Duration limited on meal
5. Tray time outs for interfering behaviors

The complete procedure is included under Specific Procedures in this chapter.

III. Specific Feeding Procedures

A. Food Acceptance Program

For some children it is necessary to increase the intake of food before attempting to develop self-feeding. This can be done by using a preferred food (something the child really likes, such as dessert, milk, meat, etc.) as a reinforcer for taking a bite of a nonpreferred food (something the child does not like). The reinforcer exchange should begin with a bite for a bite and gradually be increased to two bites of a nonpreferred food to earn a bite of reinforcer. This procedure is described in detail in Chapter 5 under "Pea-eating behavior". Once the child is accepting a variety of nonpreferred foods without reinforcement, then a feeding skill development program can be planned.

B. Intensive Feeding Skill Development

Another more rapid method of developing feeding skills was described by Azrin and Armstrong (1973). This method involves dividing the regular meals into smaller meals or "mini Meals". This technique has proven to be effective because by using several small meals per day, it provides the child with more opportunities to practice feeding himself.

Equipment needed:

1. Appropriate size table and chairs
2. Tray (and holder if necessary)
3. Spoon (or other utensils)
4. Glass
5. Napkin
6. Timer
7. Isolated room
8. Data sheets

1. Procedure

The three regular meals are to be divided into six to eight "mini-meals". For example, divided breakfast in half, and lunch and dinner into three mini-meals each. Present a meal every hour. If six meals are being used, skip one hour in the morning and one in the evening. Fifteen minutes are allowed for each meal.

2. Baseline

a. Place tray, utensil(s), napkin, and glass on table in isolated room.
b. Seat the child at the table and begin timer
c. The child is permitted to eat in any manner without interference from the observer. This includes getting out of the seat, throwing food, etc.
d. During this time, the observer is to record all feeding responses as well as other inappropriate responses which are listed on the data sheet.
e. At the end of the 15 minutes or at the completion of the meal, the child is removed from the room.
f. Three to 5 days generally establishes a stable baseline.

3. Training

At the completion of baseline, training sessions should begin in the same room. Two trainers are necessary in the beginning, but usually are not needed for the entire program. It is not necessary to continue recording the type of feeding responses during training since manual guidance will be used. However, a record should be kept of the number of meals, length of each meal and type of guidance.

a. Seat child at table and place tray, spoon napkin, and glass before him.
b. Begin the timer.
c. The meal is not begun until the child's hand not used for eating is in his lap. It may be necessary for the second trainer sitting on that side to restrain the child's hand in his lap. This restraint should be gradually faded until no longer necessary.
d. Place the spoon in the child's hand. The trainer places her hand over the child's and guides him through loading, directing to mouth, unloading, reloading, etc.
e. Social reinforcement is used for all correct feeding responses even during manual guidance. Disruptive behavior such as crying, resisting guidance, etc., can be managed in one of two ways:

    i. For children who prefer to eat - at beginning of disruption, push tray away from child and restrain hands on table until he no longer resists. If 15 minutes elapses, terminate meal.
    ii. Children who do not prefer food - continue guidance without reinforcement.

f. Firm guidance is reduced to a gentle touch as the child learns to grasps the utensil himself. Guidance should be faded as follows:

    i. Hand on hand
    ii. Hand on wrist
    iii. Hand on forearm
    iv. Hand on elbow
    v. Hand on upper arm
    vi. Hand on shoulder

g. As guidance is faded it becomes increasingly likely that the child will make errors. If an error, such as spilling should occur, overcorrection procedures and positive practice procedures are to be used.

4. Over Correction

a. Stop the meal.
b. Point out the error to the child.
c. Guide child out of chair to an area in room where a clean up cloth is located.
d. Guide him into picking up cloth and return to the table.
e. Manually guide him in cleaning up spill and returning cloth to area.
f. Return him to his chair and rapidly guide him (hand on hand) through loading and directing the spoon for a set (3-5) number of trials without putting a spoon in mouth.
g. Return to the level of guidance previously being used and resume the meal.
h. When manual guidance has been faded to the shoulder and the child is able to complete three meals with three errors or less, maintenance should begin.
i. Meals are to be terminated because of satiation.

5. Maintenance

During maintenance the child receives no guidance. Gradually reduce the number of mini meals to three regular meals. When the child has been returned to three regular meals, return him to the usual dining area.

Data collection, as in baseline, is to resume during maintenance. It is not necessary for the trainer to sit with the child, but he must be supervised as overcorrection should still be used for errors.

C. Mealtime Manners

If the intensive feeding program is used to teach independent feeding skills, table manners will be taught as a part of that program. However, if the child can already feed himself but has poor table manners, it may be necessary to plan a program to teach appropriate manners. Some inappropriate behaviors which can be extinguished are:

1. Hands on the table
2. Stuffing the mouth with food
3. Getting up from the table before the meal is finished
4. Playing in food
5. Stealing food

Most of these behaviors can be managed by using a tray time out. This type of time out involves pushing the child's plate out of reach for a brief period, usually until the inappropriate behavior stops. The plate is then returned and the meal continued. Correct behaviors, such as keeping one hand in the lap, should be demonstrated to the child. Also, allowing the child to observe another child (modeling) who uses correct table manners might be a useful tool. Correct responses should always be reinforced with praise and physical touch, if at all possible.

D. Review

There are a variety of methods that can be used to develop feeding skills. The important thing to remember, no matter what approach is used, is that food is a reinforcer. If incorrect or inappropriate responses are made and the child continues to receive the food without being corrected, then these behaviors will be strengthened.

IV. General Toileting Principles

The goal of a toilet training program is to teach the child to go to the toilet independently when he needs to eliminate (bowel or bladder). Before beginning a program, a baseline should be done for at least five days to determine the child's elimination habits. It is also important to acquaint the child with the bathroom to prevent him from being frightened.

A method which often precedes independent toileting is scheduling or tripping. The goal of this program is to teach the child to hold his urine or bowel movements until he is taken to the bathroom. This does not require as much of the child, because he does not have to associate his urge to go with getting up and going into the bathroom. He is merely regulated by a schedule and is able to suppress his urge until he is taken. This method is particularly useful for nonambulatory individuals.

Scheduling involves taking the child to the toilet, usually every hour in the beginning. As successes increase, the intervals between being taken to the bathroom increase, i.e., to two hours, then 2½ hours, etc. The goal is to have the child reach a schedule that is convenient for child, parent, and/or trainer. This might mean after meals, bedtime, and early morning.

V. Specific Toileting Procedures

A. Independent Toileting

The program should be planned for waking hours only at first. After this is accomplished, a night time schedule can then be planned. The child should be dressed in loose training pants and a shirt for convenience. The procedure used involves chaining, which is the reinforcement and repetition of each step until it is learned and then progressing to the next steps. The steps used in training are as follows:

- a. Goes into bathroom
- b. Pulls his pants down
- c. Sits
- d. Eliminates
- e. Stands up
- f. Wipes (if necessary)
- g. Flushes toilet
- h. Pulls up pants
- i. Washes and dries hands
- j. Leaves bathroom

B. Intensive Toilet Training Program

This program has been adapted from the rapid method of toilet training the retarded by Azrin, Foxx, and O'Brien (1974).

1. Materials Needed:

   - a. small table and chairs
   - b. several pairs training pants
   - c. paper towels
   - d. mop
   - e. simple toys
   - f. food and liquid rewards:
     crackers, peanut butter and jelly,
     bread, candy, ice cream, potato chips,
     coke, juice, chocolate milk

2. Procedure:

   - a. Child should wear only shirt, training pants, socks. Remove shoes, long dresses, or outer pants.
   - b. Child should be in room close to a bathroom.
   - c. Give child food and liquid constantly throughout day. Encourage him to eat and drink.
   - d. Approximately every 30 minutes ask child if he is dry -- "Michael, are you dry?" Show him how to touch his pants to check. Reward him for correct response.
   - e. Then tell child to use bathroom -- "Go to the bathroom, Michael".

In the beginning give the command for each step in the toileting process: if child does not respond within 3 seconds, then guide his hands through each step. Once he has learned a step (that is, he responds within 3 seconds, then do NOT help him). Once he begins a step on his own and performs correctly, then stop giving the command for that step.

Commands for each step:

i. "Go to the bathroom"
ii. "Take down your pants"
iii. "Sit on the toilet" (he should sit there for approximately 1 minute unless he eliminates, in which case he may get up)
iv. "Get up"
v. "Get the tissue"
vi. "Wipe yourself"
vii. "Throw away tissue"
viii. "Flush the toilet"
ix. "Pull up your pants"
x. "Wash your hands"
    a. "Turn on water"
    b. "Use soap"
    c. "Rinse hands"
    d. "Turn off water"
    e. "Dry hands"
    f. "Throw away towel"
    g. "Sit in your chair"

Child should be praised and rewarded for completing each step in the whole procedure. This whole process of going to the bathroom is called POSITIVE PRACTICE.

f. Approximately every 30 minutes ask the child if he is dry, show him how to touch his pants, and have him go to the bathroom. Gradually fade out your verbal commands and manual assistant as the child learns to follow the routine on his own.

The idea is that the child should learn to perform a whole chain of responses to a single command -- "Go to the bathroom" -- from approaching the toilet all the way to sitting in his chair after he has washed his hands. Thus, it is extremely important that you fade out as soon as possible, otherwise the child will always be dependent upon your telling him what to do.

g. If the child goes to the toilet on his own (without your command) at any time, he should get lots of praise and reward because this is our goal. When he has gone a few times without being told to do so then you can gradually increase the time between positive practices to 45-60 minutes. Eventually, the child should learn to go when he feels pressure and not when you tell him to go.

h. When the child has been going on his own several times, then STOP using positive practice and merely ask him -- "Are you dry?" (approximately every 20 minutes). He is still encouraged to eat and drink, and should receive lots of praise and a special treat when he uses the toilet.

i. One to two days after the child has been using the toilet independently and is able to go through the whole process without verbal or physical assistance, the constant reinforcers are no longer necessary and the program is complete.

3. OVERCORRECTION for TOILET ACCIDENTS (Urine or Bowel)

This procedure is an important part of the Toilet Training Program, and it must be applied every time there is an accident with NO EXCEPTIONS. The following are the steps of overcorrection to be used for toileting accidents.

a. Speak in a firm, stern voice which will let the child know that you are upset and angry.

b. In the same tone of voice and moving quickly, give the child the following commands:

   i. "Take off your pants"
   ii. "Wash your pants"
   iii. "Wash yourself"
   iv. "Wash the floor, toilet, etc."
   v. "Put on your pants (socks, shoes, etc.)"

Again, if the child fails to respond within 3 seconds, guide his hands through each step. Make sure that he is physically involved in the work. Do NOT do the work for him. When he is clean, make him wash more. Make him continue to clean the area, even after it is clean. This is why the process is called "Overcorrection". The child must not only correct the situation, but he must also make it better than it was before the accident.

C. Ignore all crying, protesting, etc. Simply guide the child firmly with your hands. DO NOT REWARD OR PRAISE THE CHILD AT ANY TIME DURING OVERCORRECTION. This is supposed to be an unpleasant activity, which means he is receiving negative consequences for having had an accident.

D. When the overcorrection is completed, the child must carry out 3 positive practices in rapid succession. Use a stern voice and do NOT give rewards or praise.

VI. Dressing Procedures

This skill is sometimes taught before toileting or as a part of the toilet training program. Usually undressing is taught first, because most children learn to do this with no instruction at inappropriate times. They must then be shaped to undress on command. For both dressing and undressing, the use of a chaining procedure is most frequently recommended. The steps for teaching a child to put on a T-shirt would be as follows:

1. Allows trainer/parent to put on shirt
2. Pulls shirt tail down
3. Puts arms through and pulls shirt down
4. Puts head and arms through and pulls shirt down.
5. Puts shirt on if handed to him in correct position
6. Picks up shirt and puts it on with no directions

This procedure can be utilized for teaching all types of dressing, i.e., pants, socks, coats, etc. Always teach the last step in dressing first and move on only after the child has mastered that step.

Once the child has learned to dress and undress completely, then buttoning, zipping, and lacing can be taught in that order. Chaining with prompting and modeling, can also be used to develop these skills. It would be helpful to begin by using large buttons and button holes. Always reinforce correct responses or approximations if the program has just begun.

VII. Personal Grooming Procedures

This area includes such tasks as:

1. Bathing
2. Brushing teeth
3. Combing or brushing hair

Before attempting to teach any of these skills, the task should be demonstrated to the child. It might also be helpful to allow him to observe a child who has mastered the skill. For instance, while brushing a child's teeth have another child who can brush his teeth do so at the same time.

The use of graduated manual guidance to develop these skills is probably the most useful technique. Correct responses should be reinforced and errors corrected. Make the learning experience pleasant so that the child does not become fearful.

References

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